

BLAKE, SUSAN D., Ph.D. Ready Or Not: A Qualitative Investigation of the Experiences of Entry-Level Professional Counselors Working in Community Mental Health Settings and Potential Impacts to Wellness. (2015)
Directed by Dr. Todd F. Lewis and Dr. Keith Mobley. 403 pp.

It is well known that professional counselors may experience physical and emotional symptoms that may ultimately affect their quality of work (Figley, 1995; Figley, 2002; Maslach, 2003). Furthermore, deficits in wellness of counselors can have significant consequences in the ethical care of clients (ACA, 2005; 2014; Kocet, 2006; Neumann & Gamble, 1995; Pearlman & Saakvitne, 1995). Specifically, entry-level professional counselors in community mental health (CMH) settings may be at a higher risk of experiencing these deficits to wellness compared to their more experienced counterparts (Farber, 1985; Lawson & Myers, 2011; Lent & Schwartz, 2012; Pearlman & MacIlan, 1995; Sprang, Clark & Whitt-Woosley, 2007). In addition, entry-level counselors may not have the skills or support to maintain their wellness and thus protect them from impairment stemming from organizational variables within the CMH setting (Lawson, 2007; Farber, 1985; Pearlman & MacIlan, 1995; Sprang et al., 2007). As such, the challenging clientele, organizational factors, and supervision experiences in CMH settings may have unique influences on entry-level professional counselors' experiences with wellness. Unfortunately, a common trend in CMH agencies is that the least experienced counselors work with the most severe of client needs (Pearlman & MacIlan, 1995; Wachter Morris & Barrio Minton, 2012).

Researchers have begun to examine elements of wellness among counseling students (Lambie, Smith, & Ieva, 2009; Myers, Mobley & Booth, 2003; Perepiczka &

Balkin, 2010; Roach & Young, 2007), counselor educators (Wester, Trepal, & Myers, 2009) and professional counselors (Lawson, 2007; Lawson & Myers, 2011; Lent & Schwartz, 2012; Mobley, 2004; Randolph, 2010). Surprisingly, however, greater emphasis on wellness and prevention of impairment as well as calls in the literature for managing impairment factors within the field of counseling (Lawson & Venart, 2005; Sheffield, 1998; Witmer & Young, 1996) has not spurred empirical investigation related to the experiences of entry-level professional counselors. Furthermore, the work environment of entry-level professional counselors, and how this impacts their experiences of wellness, has been largely neglected (Borders & Hamilton Usher, 1992; Fall & Sutton, 2003; Freadling & Foss-Kelly, 2014). As such, continuing to overlook the needs of entry-level professional counselors poses not only a risk to counselor wellness but also to client welfare (Lawson & Venart, 2005).

Therefore, the purpose of this study was to investigate the experiences of entry-level professional counselors working within CMH agencies and how these experiences impact their wellness. In particular, the experiences of entry-level professional counselors were explored within the context of the clientele they typically serve, the organizational factors they face on a daily basis, and the supervision they receive as entry-level counselors. Consensual Qualitative Research (CQR) was utilized to analyze the interviews of 11 participants.

Participants in this study identified multiple factors that impacted their experiences of working in the CMH setting. The research team reviewed data presented by participants and developed eight domains. These domains included categories that

were labeled general, typical, and variant. The domains were developed based on literature review and participant responses. These included: (a) job title or role, (b) ProQOL experience, (c) career choice, (d) organizational factors, (e) client factors, (f) self-care/ wellness, and (g) supervision. Of the 42 categories, 3 were labeled general, 20 were labeled typical, and 19 were labeled variant.

READY OR NOT: A QUALITATIVE INVESTIGATION OF THE EXPERIENCES
OF ENTRY-LEVEL PROFESSIONAL COUNSELORS WORKING
IN COMMUNITY MENTAL HEALTH SETTINGS
AND POTENTIAL IMPACTS
TO WELLNESS

by

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A Dissertation Submitted to
the Faculty of The Graduate School at
The University of North Carolina at Greensboro
in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

Greensboro
2015

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APPROVAL PAGE

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ACKNOWLEDGMENTS

So many people have been involved in the process of completing this project that I am sure one page will not come close to noting all of them. First, I would like to thank my committee for the long-term support that you offered. Dr. Todd Lewis, you have been there through all the changes and challenges. I appreciate your support and very calming energy. Dr. Keith Mobley, you have such a mentor's spirit and approach. I cannot thank you enough for all your encouragement. Dr. Darlene Xiomara Rodriguez, your challenges and high expectations certainly pushed me through to completion. You never gave up and I thank you for that. Dr. Kelly Wester, your feedback was helpful and I truly appreciate you stepping onto the committee after so many changes had occurred. To the late, Dr. Jane E. Myers, you may not have seen this project to its end but your influence certainly continues. Your research agenda continues through the lives of so many. I hope I made you proud.

To my research team: Dr. Amber Pope and Dr. Denisha Champion, I couldn't have done this without you both. Your words of encouragement went further than you know. Your help in sorting out the data and taking precious time out of your busy lives to get me to this point is nothing less than inspiring.

To the amazing people at Tree of Life Counseling, you help to create an environment of healing not only for the clients we see but also for each other. Jennifer Rosenbluth, you always supported and encouraged me. I appreciate you all listening to my worries and victories along this journey.

To the Tenacious Ten, we met when life was uncertain for me in many ways. You each had a part in making me the woman I am today. My family and friends, you had no idea what I was doing all those long nights and weekends when I had to turn down invitations. You loved and supported me in spite of it all.

To Sonya, my love, my partner, you have only known me with this present in my life. You loved me anyway. You consistently make me a better and kinder soul in this world. You are my soft place to land. I love you with all my heart and I am so excited to see what is in store for our lives together. I am grateful.

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CHAPTER I

INTRODUCTION

The breadth and reach of impaired wellness and counselor burnout are significant professional concerns, especially among entry-level professional counselors within the context of Community Mental Health (CMH) settings (Acker, 2010; Farber, 1985; Freadling & Foss-Kelly, 2014; Lawson & Myers, 2011; Lent & Schwartz, 2012; Pearlman & MacIlan, 1995; Randolph, 2010; Sprang, Clark & Whitt-Woosley, 2007). Despite these concerns, and the relatively common occurrence of counselor burnout (Lawson, Venart, Hazler, & Kottler, 2007; Maslach, 2005; Lee, Cho, Kissinger & Ogle, 2010) counselor wellness remains a significant focus in the counseling literature (ACA, 2005; Cummins, Massey, & Jones, 2007; Kocet, 2006; Myers & Sweeney, 2005; Myers & Sweeney, 2008), although most research has centered on counselors-in-training (CITs) (Lambie, Smith, & Ieva, 2009; Myers, Mobley & Booth, 2003; Perepiczka & Balkin, 2010; Roach & Young, 2007). Researchers have largely overlooked the experiences of post-graduate entry-level professional counselors (Borders & Brown, 2005; Freadling & Foss-Kelly, 2014; Lawson, 2007; Lawson & Myers, 2011; Mobley, 2004; Skovholt & Trotter-Mathison, 2012), necessitating research on this population.

Understanding the unique experiences of entry-level professional counselors within the context of CMH agencies and supervisory experiences, and how these impact their wellness can help them better navigate the inevitable stressors that arise as they

enter the CMH workforce. (Freadling & Foss-Kelly, 2014; Lent & Schwartz, 2012; Randolph, 2010). Assisting entry-level professional counselors in the transition from a training setting into the potentially difficult environment of CMH agencies may empower counselors to maintain a strong sense of professional identity and wellness that will embolden them throughout their careers (Gibson, Dollarhide & Moss, 2010; Gibson, Dooley, Kelchner, Moss & Vacchio, 2012). Unfortunately, a common trend in CMH agencies is that the least experienced counselors work with the most severe of client needs (Pearlman & MacIlan, 1995; Wachter Morris & Barrio Minton, 2012). As such, continuing to overlook the needs of entry-level professional counselors poses not only a risk to counselor wellness but also to client welfare (Lawson & Venart, 2005). Exploring the experiences of entry-level professional counselors in the CMH setting may provide direction for training and supervision so as to optimize their introduction to professional counseling (Borders, 2005; Fall & Sutton, 2003).

In this chapter, research on entry-level professional counselors, and two contextual factors that may impact their experiences of wellness, working in a CMH agency and supervisory experiences, will be discussed. A brief overview of wellness and impairment literature is provided to underscore the scope of the problem. The potential usefulness of understanding the unique experiences of entry-level professional counselors within the clinical mental health setting and supervisory experiences that impact their wellness is provided. The integration of research on the dynamics of entry-level professional counselors, CMH settings, supervision, and counselor wellness is presented in a succinct statement of the problem followed by a discussion of the purpose of the

study and presentation of the research questions. The chapter concludes with definitions of key terms and an overview of the remaining chapters.

Entry-Level Professional Counselors

A significant oversight has emerged in the counseling literature in which experiences of counselor wellness have been mainly studied among graduate students in counseling programs, whereas the experiences and needs of entry-level professional counselors (i.e. counselors working professionally following graduation and maintaining requirements toward an independent license) remain unknown (Lambie, Smith & Ieva, 2009; Myers, Mobley & Booth, 2003; Perepiczka & Balkin, 2010; Roach & Young, 2007). Beyond formal training experiences, there is limited knowledge and understanding of what specific needs arise for entry-level professional counselors. Additionally, the work environment of entry-level professional counselors, and how this impacts their experiences of wellness, has been neglected (Borders & Hamilton Usher, 1992; Fall & Sutton, 2003). Some studies have begun to identify the experiences of entry-level counselors by including age and/or experience levels as a factor in their research criteria (Lawson & Myers, 2011; Lawson, 2007; Lent & Schwartz, 2012; Randolph, 2010); however, few researchers have specifically examined entry-level professional counselor experiences in the context of work setting (Freadling & Foss-Kelly, 2014). Despite licensure regulations for supervision of entry-level counselors entering the field, few researchers have considered the supervision experiences of entry-level professional counselors as well (Borders, 2005; Borders & Brown, 2005; Fall & Sutton, 2003).

It is well known that professional counselors may experience physical and emotional symptoms such as a disruption in a sense of safety and distressing thoughts that may ultimately affect their quality of work (Figley, 1995; Figley, 2002; Maslach, 2003). Furthermore, deficits in wellness of counselors may have great consequence in the ethical care of clients (ACA, 2005; Kocet, 2006; Neumann & Gamble, 1995; Pearlman & Saakvitne, 1995). Specifically, entry-level professional counselors may be at a higher risk of experiencing these deficits to wellness compared to their more experienced counterparts (Farber, 1985; Lawson & Myers, 2011; Lent & Schwartz, 2012; Pearlman & MacIan, 1995; Sprang, Clark & Whitt-Woosley, 2007). Researchers have concluded that those with less experience in the counseling field tend to score higher on measures of burnout and trauma (Farber, 1985; Lawson & Myers, 2011; Pearlman & MacIan, 1995; Sprang et al., 2007). It also has been suggested that younger aged counselors experience more symptoms of burnout, suggesting less wellness (Garner, Knight & Simpson, 2007; Sprang et al., 2007).

Entry-level professional counselors transitioning from graduate school may be more likely to seek employment in CMH settings rather than private settings due to needs around supervision and employment benefits (Freadling & Foss-Kelly, 2014; Randolph, 2010). Researchers have established that the setting of CMH brings a higher risk of impairment for counselors (Lawson, 2007; Lawson & Myers, 2011; Lent & Schwartz, 2012; Randolph, 2010; Sprang et al., 2007). Community settings tend to serve clients with higher risk levels of lethality, trauma experiences, crises, and more pervasive mental disorders (Acker, 2004; Lawson & Myers, 2011; Isett et al., 2009; Sprang et al., 2007;

Walsh & Walsh, 2002). These more complex client issues may be a significant challenge to an entry-level professional counselor. Supervision has been offered as a supportive instrument for entry-level professional counselors to maintain wellness, professional identity, and continue professional development (Lenz, Sangganjanavanich, Balkin, Oliver, & Smith, 2012; Lenz & Smith, 2010; Venart, Vassos, & Pitcher-Heft, 2007).

Counselor Development and Supervision

Counselor development in reaction to critical learning experiences has become a central tenet in the field of counseling primarily identified as being facilitated in clinical supervision (Borders & Brown, 2005; Borders & Usher, 1992; Loganbill et al., 1982; Worthington, 1987). Clinical supervision takes place face-to-face and is facilitated by a supervisor who is generally considered a more senior counselor with the goals of skill development, clinical competence, monitoring client welfare, and supervisee self-awareness (Bernard & Goodyear, 1998; Loganbill et al., 1982; Tromski-Klingshirn & Davis, 2007). Entry-level professional counselors are generally required to maintain formal supervision during the early years of their professional work. This requirement has been mandated by every state in the U.S. (Bergman, 2013; Borders, 2005; Fall & Sutton, 2003; Goldberg, Dixon & Wolf, 2012; Magnuson, Norem & Wilcoxon, 2000; Sutton, 2002; Wilcoxon & Magnuson, 2002) and is proposed as a helpful contribution to the development and wellness of entry-level professional counselors (Bober & Regehr, 2006; Cummins, Massey & Jones, 2007; Etherington, 2000; Etherington, 2009; Freadling & Foss-Kelly, 2014; Harrison & Westwood, 2009; Hesse, 2002; Knight, 2004; Lenz &

Smith, 2010; Myer & Ponton, 2006; Trippany, Kress & Wilcoxon, 2004; Sexton, 1999; Sommer, 2008; Somer & Cox, 2005; Young & Lambie, 2007).

Several themes in counselor development have emerged throughout the literature. These include the commonly reported experiences related to developing professional identity, self-awareness, personal reactions, a sense of competency, counseling philosophy, and supervision (Heppner & Roehlke, 1984; Howard et al., 2006; Skovholt & Rønnestad, 2003). However, researchers have not yet fully explored the actual experiences of professional counselors beyond the context of graduate school (Borders & Hamilton Usher, 1992; Fall & Sutton, 2003; Freadling & Foss-Kelly, 2014; Schultz, Ososkie, Fried, Nelson & Bardos, 2002). Indeed, Borders and Brown (2005) highlighted that most development and supervision research has been focused on students or on earlier developmental stages and that there is limited information on post degree supervision and counselor development. These experiences, within the context of CMH settings, may provide important information regarding how supervision impacts entry-level professional counselor wellness and development.

Increasing the complexity of their vulnerability, entry-level professional counselors also have the task of developing a continued professional identity, which has been linked to a greater sense of wellness (Lawson & Myers, 2011). Gibson, Dollarhide, and Moss (2010) noted that professional identity seems linked to a counselor's ability to integrate both skills and attitudes as a professional and as having a place in a professional community. Gibson, Dooley, Kelchner, Moss and Vacchio (2012) also indicated that a sense of competency contributes to a professional identity. Developing and maintaining

professional identity may be a challenge for entry-level professional counselors who received limited exposure during formal education to issues of crises, trauma, and other client issues prevalent in CMH settings; as such, they may experience a lack of confidence or readiness to address such issues.

Considering that a counselor may be experiencing a stage of confusion upon graduation (Loganbill et al., 1982) and entering the mental health field in a more independent role, Borders and Brown (2005) suggested that supervisors should have a very active role. They noted that it is at the mid-stages of counselor development (i.e., post-graduate vs. early stages of development while still in training) when confusion occurs and supervisors have significant opportunities to assist counselors in understanding how their interactions with clients may be impacting them as a person. Exploring the supervision experiences of entry-level professional counselors in the unique environment of CMH settings will provide direction for supervisors taking on this challenging role of support.

Community Mental Health Settings

Limited attention has been given to work settings of counselors and the impact these may have on their sense of wellness (Freadling & Foss-Kelly, 2014; Lent & Schwartz, 2012). Counselors in CMH agency settings tend to report higher levels of burnout and deficits to wellness than counselors in private practice or university settings (Lawson & Myers, 2011; Lawson, 2007; Lent & Schwartz, 2012; Randolph, 2010). Counselors working in CMH settings also have a need to navigate both organizational factors such as public funding, limited resources or outcome-based practices (Acker,

2010; Barak, Nissly & Levin, 2001; Bell, Kulkarni & Dalton, 2003; Lawson & Myers, 2011; Maslach & Leiter, 1997) along with a more challenging clientele (Briere & Jordan, 2004; Lindhorst, Macy & Nurius, 2005). This is especially the case for entry-level professional counselors (Farber, 1985; Lawson & Myers, 2011; Lent & Schwartz, 2012; Pearlman & MacIain, 1995; Sprang, Clark & Whitt-Woosley, 2007).

Organizational Factors

Several organizational factors in CMH agencies may influence entry-level professional counselors' experience of wellness. (Bell et al., 2003; Lawson & Myers, 2011; Lent & Schwartz, 2012). These factors include managed care issues, funding restraints, limited resources, and significant paperwork referred to as administrative burden (Isett et al., 2009). Many of these unique organizational challenges are not covered in depth in traditional counselor training programs leaving entry-level professional counselors unprepared (Skovholt & Rønnestad, 2003). Particularly in a nonprofit setting, resources may be limited (Lent & Schwartz, 2012; Sprang et al., 2007) and additional responsibilities or pressures of reporting success in client care programs may obstruct counselor practice and autonomy (Acker, 2004; 2010; Lawson & Venart, 2005). These demands are especially troubling for counselors who are transitioning into professional practice.

Counselors in the CMH setting must now adhere to guidelines of practice that do not necessarily take into account best practice for client care but rather focus on financial limitations or outcomes measurements with the goal being low-cost and efficient care for those with severe mental illness (Acker, 2010; Acker, 2004; Cohen, 2003; Isett et al.,

2009; Scheid, 2003). Counselors in the community sector may be especially vulnerable to the effects of managed care (Acker, 2004; 2010) and must satisfy a more stringent need to meet demands of compliance and accreditation regulations within their organizations rather than focus on client care (Lent & Schwartz, 2012). For example, CMH counselors may be required to follow more stringent documentation or reporting measures than private practice or school settings. CMH counselors may be asked to utilize specific treatment modalities as standardized by their state, such as family preservation or home-based counseling, thus limiting their sense of autonomy (Isett et al., 2009; Lawson, 2005). Unique concerns such as funding restraints and limited resources can impact counselors' ability to serve clients effectively (DeStefano, Clark & Potter, 2005).

Challenging Clientele

Considering that CMH agencies are likely to serve a client population with more limited resources it is possible that this setting attracts a higher number of clients with greater suicide or lethality risks, severe mental illness, and clients with a high level of trauma (Acker, 2010; Gaal, 2009; Sprang et al., 2007; Young & Lambie, 2007). Caseload factors such as a greater number of high-risk clients (e.g., suicidal ideation and patterns, self-injurious; domestic violence or other lethality potential, co-morbidity) and those with more pervasive mental health problems have been related to increases in counselor distress (Acker, 2004; Lawson & Myers, 2011; Isett et al., 2009; Walsh & Walsh, 2002). Caseloads with greater numbers of clients with victimization or violent or human-induced trauma may be associated with a greater risk for Compassion Fatigue (CF) and Secondary Traumatic Stress (STS) (Creamer & Liddle, 2005; Cunningham, 2003). Entry-level

professional counselors may have limited exposure and training to address the needs of this population resulting in potential deficits in counselor self-efficacy and, as a consequence, may jeopardize client welfare (Barrio Minton & Pease-Carter, 2011; Gibson, Dollarhide & Moss, 2010; Wachter Morris & Barrio Minton, 2012).

Exposure to interpersonal trauma could lead potentially to several forms of impairment such as burnout, compassion fatigue, vicarious trauma, and secondary traumatic stress (Newell & MacNeil, 2010; Stamm, 2010). Furthermore, interpersonal trauma or trauma that is caused by human interaction (e.g., sexual trauma, intimate partner violence, rape), is prevalent and impacts nearly all CMH counselors (Trippany, White-Kress & Wilcoxon, 2004).

For instance, sexual trauma comes in many forms, including childhood sexual abuse (CSA), rape and sexual assault. Rates of CSA have been found to be as high as 35% for women and 20% for men (Briere & Elliot, 2003; Finkelhor, Hotaling, Lewis & Smith, 2004). Rape statistics have been reported as high as 20% for women (Black et al., 2011; Tjaden & Thomas, 2000). Symptoms experienced by clients with a history of trauma have been reported to include such difficult counseling issues as post-traumatic stress disorder (PTSD), borderline personality disorder, interpersonal conflicts, anxiety, and severe depression (Briere & Elliot, 2003). Considering the great amount of potential exposure to sexual trauma, it is clear that entry-level counselors may be faced with issues that require high need and skill with which they may be deficient.

Intimate partner violence (IPV), or domestic violence, is another stressful and high-empathy concern that counselors often address in CMH practice. Incidence of IPV

is reported to occur at the rate of at least 25% with an estimated 1.3 million women as victims (Black et al., 2011; Tjaden & Thoennes, 2000; Centers for Disease Control and Prevention, 2003). It is estimated that only one quarter of physical assaults in intimate relationships is reported to law enforcement (Tjaden & Thoennes, 2000; United States Department of Justice, 2003). Victims of IPV may seek assistance from a CMH agency thus necessitating a counselor to address safety and trauma in response to these difficult situations (Briere & Elliot, 2004; Lindhorst, Macy & Nurius, 2005).

Counselors in CMH settings also may be faced with issues of suicidal clients. Suicide was reported as the third leading cause of death among individuals aged 15 – 24 (Arias, Anderson, Kung, Murphy & Kochanek, 2003). In spite of the prevalence of lethality issues in society, entry-level professional counselors may not have the support or skills needed to effectively handle these crises presented by clients (Barrio Minton & Pease-Carter, 2011; McGlothlin, Rainey & Kindssvatter, 2005; Wachter Morris & Barrio Minton, 2012). It is clear from past research that counselors report significant stress when dealing with this type of client issue (Bonnar & McGee, 1977; Granello, 2010; Hendin, Lipschitz, Matsberger, Haas & Wynecoop, 2000). Given the documented prevalence and complexity of client issues presented in a CMH counseling agencies, it seems likely that counselors are at risk for some mental or emotional disturbances that impacts their wellness (Lawson & Myers, 2011; Sprang, Clark & Whitt-Woosley, 2007).

Whereas there is limited information regarding counselors entering the workforce and the specific types of jobs and duties taken following graduation, it seems reasonable to assume that the CMH agency settings are where a great number of entry-level

professionals enter the field upon completion of graduate work (Freadling & Foss-Kelly, 2014; Randolph, 2010). Understanding the clinical mental health agency environment, and how this environment impacts entry-level professional counselors' experience of wellness, may help establish ways to assist them in successfully navigating potential stressors that will inevitably arise and strengthen wellness. Most entry-level professional counselors are not in a position to begin a private practice soon after graduation and many will be seeking professional benefits such as supervision or established caseloads along with expected financial benefits such as health insurance that may be provided by CMH organizations. An awareness of these issues may assist counselors, educators, supervisors and organizations in monitoring wellness and impairment impacts on client care.

Counselor Wellness and Impairment

Wellness has become a central paradigm within the field of counseling (Myers, 1991; Myers, 1992; Myers & Sweeney, 2008). Research has supported the use of a wellness framework across several types of clients and client issues (Myers & Sweeney, 2005; Myers & Sweeney, 2008); however, there is limited research on the wellness of counselors themselves. Multiple authors have suggested that self-care and wellness of counselors must be given priority in order to ensure that counselors do not cross ethical lines in the treatment of clients (Cummins, Massey, & Jones, 2007; Myer & Ponton, 2006; Young & Lambie, 2007). In addition, when counselors do not practice self-care, both professionally and personally, they risk becoming ineffective or incompetent as a counselor (Skovholt, 2001). Skovholt (2001) noted that counselors could display signs

that there is a problem with wellness in many areas of life including physical, emotional, spiritual, and intellectual. These deficits can take the form of forgetfulness or a lack of attention to details. Lack of wellness can lead to counselors feeling emotionally or physically exhausted as well as other symptoms including anxiety, depression or physical symptoms (e.g., headaches). Furthermore, a lack of wellness may result in impairment, which may in turn create deficits in counselor competence and ability to care for clients (Emerson & Markos, 1996; Lawson & Myers, 2011; Lawson, 2007; Sheffield, 1998).

Figley (2002) has identified that when counselors work with trauma they are at risk for experiencing symptoms similar to Posttraumatic Stress Disorder (PTSD), which can include a disruption in a sense of safety and distressing thoughts. Researchers have identified that many of these reactions may cause counselors to feel less work satisfaction or a deficit in empathy (Sherman & Thelen, 1998). A deficit in wellness may not lead to full impairment but can result in a counselor behaving in a less than professional manner such as cancelling appointments, being late to sessions, or missing other important job requirements (Cummins, Massey, & Jones, 2007). Researchers have noted that further exploration of the factors that impact counselor wellness is needed (Lawson & Myers, 2011; Myers & Sweeney, 2008; Roach & Young, 2007), especially among those outside of traditional research samples such as counselors-in-training. (Lambie et al., 2009; Myers, Mobley, & Booth, 2003; Perepiczka & Balkin, 2010; Roach & Young, 2007). The issues related to wellness have not been thoroughly examined among practicing professional CMH, especially entry-level professionals.

Whereas counselors tend to emphasize how to optimize wellness it also is important to understand impairment and how it may manifest for counselors (Lawson, 2007; Lee, Cho, Kissinger, & Ogle, 2010). Although impairment definitions may vary, four key components are identified in the related literature. These include (a) burnout, (b) compassion fatigue, (c) vicarious trauma, and (d) secondary traumatic stress (Newell & MacNeil, 2010; Stamm, 2010).

Witmer and Young (1996) called for a wellness approach to preventing impairment of counselors, and noted the absence of research on the dynamics of counselor impairment. The authors offered an approach in which a comprehensive strategy toward wellness could be facilitated as a prevention of impairment. In 2003, The American Counseling Association (ACA) commissioned a Task Force to address wellness and impairment of counselors and provide a working definition for the field.

The task force stated “...therapeutic impairment occurs when there is a significant impact on a counselor’s professional functioning which compromises client care or poses the potential for harm to the client” (Lawson & Venart, 2005). The task force included that impairment may occur when there is a mental illness, personal crisis, physical debilitation or substance abuse present for the counselor. They were clear in pointing out that impairment is not an unethical behavior but rather unethical behavior may occur because of the impairment. Although stress may be a factor in mental illness, personal crisis, physical debilitation, or substance abuse, the task force noted (a) that impairment is different than stress or distress and (b) that a counselor may experience stress without

becoming impaired. However, left unaddressed, excessive degrees of counselor stress and inadequate or ineffective coping interventions may develop into impairment.

Kocet (2006) noted that in the 2005 revision of the ACA Code of Ethics special attention was given to issues of counselor impairment. He implied that acknowledgement of the professional difficulties that counselors face led to more details in the standards addressing impairment. Impairment of counselors was directly addressed in the ACA Code of Ethics (2005) and is maintained in the 2014 revisions. The 2014 Code of Ethics states:

Counselors monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when impaired. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until it is determined that they may safely resume their work. Counselors assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted with colleagues or supervisors showing signs of impairment and intervene as appropriate to prevent imminent harm to clients. (ACA, 2014; C.2.g)

The counseling field has clearly become more aware of the needs regarding impairment. Self-care and wellness is promoted widely in the counseling literature (Cummins et al., 2007; Osborn, 2004; Venart et al., 2007). Bell, Kulkarni, and Dalton (2003) suggested that organizations must create a culture that acknowledges these difficulties and can help counselors feel supported. Potential methods of increasing wellness and limiting impairment must recognize the counselor's personal and professional needs (Lenz & Smith, 2010; Young & Lambie, 2007). However, research on professional self-care and wellness specifically with CMH counselors continues to be sparse. These are all issues

that greatly impact professional counselors. Unfortunately, these issues and concerns have not been fully explored among professional counselors, and few researchers have explored them among entry-level professional counselors.

Purpose of the Study

The purpose of this study was to investigate the experiences of entry-level professional counselors working within CMH agencies and how these experiences impact their wellness. In particular, the experiences of entry-level professional counselors were explored within the context of the clientele they typically serve, the organizational factors they face on a daily basis, and the supervision they receive as entry-level counselors. The researcher sought to investigate the unique voices and opinions of practicing entry-level professional counselors in an effort to understand more fully their hurdles, protective factors, and other experiences related to wellness, in the context of a CMH agency setting. Understanding of entry-level counselor experiences related to wellness in this specific context may lead to greater awareness of effective management and support from counselor educators, supervisors and organizations as a way to optimize wellness and prevent impairment. Ultimately, good counselor care and wellness will lead to good client care (Lawson & Venart, 2005).

Multiple authors have suggested that the further study of professional counselors is warranted (Borders & Brown, 2005; Lawson & Myers, 2011). In particular, understanding the experiences of counselors transitioning into more independent practice from the setting of graduate school may lead to an increase of wellness (and, consequently, a decrease in impairment) in counselors. Even with all the suggestions

offered in the literature, there remains no research-based evidence of what promotes or prevents wellness for entry-level professional counselors; essentially no voice from these professional counselors in the literature.

The results of this study offer insight into various factors (i.e., clientele served, organizational factors, supervision) within CMH agencies that promote wellness or discourage impairment among entry-level professional counselors. As such, the results of this study have potential to add to the burgeoning research related to wellness among other factions of the counseling profession (i.e., counselor educators, seasoned professional counselors, effective supervisory interventions). The use of a rigorous qualitative methodology allowed for exploration and discovery of variables that can be further investigated in future research studies. Allowing entry-level counselors to express their experiences provided a base in the literature to move forward with more empirical studies of what actually strengthens or hinders entry-level professional counselor wellness.

Statement of the Problem

Current literature affirms that counseling is a profession where promotion of wellness is emphasized (Myers & Sweeney, 2008). Researchers have begun to examine elements of wellness among counseling students (Lambie, Smith, & Ieva, 2009; Myers, Mobley & Booth, 2003; Perepiczka & Balkin, 2010; Roach & Young, 2007), counselor educators (Wester, Trepal, & Myers, 2009) and professional counselors (Lawson, 2007; Lawson & Myers, 2011; Lent & Schwartz, 2012; Mobley, 2004; Randolph, 2010). Surprisingly, however, greater emphasis on wellness and prevention of impairment as

well as calls in the literature for managing of impairment factors within the field of counseling (Lawson & Venart, 2005; Sheffield, 1998; Witmer & Young, 1996) has not resulted in empirical investigation of experiences of entry-level professional counselors who work in CMH agencies. Entry-level professional counselors are at higher risk of impairment than more experienced counselors (Farber, 1985; Lawson & Myers, 2011; Pearlman & MacIlan, 1995; Sprang et al., 2007), and may not have the skills or support to maintain their wellness and thus protect them from impairment or lack of competence stemming from organizational variables within the CMH setting (Lawson, 2007; Farber, 1985; Pearlman & MacIlan, 1995; Sprang et al., 2007). As such, the challenging clientele, organizational factors, and supervision experiences in CMH settings may have unique influences on entry-level professional counselors' experiences with wellness.

This qualitative study addressed this gap in the literature by investigating entry-level professional counselors' experiences within CMH settings and how those experiences impacted their sense of wellness. The current study was designed to explore these experiences within the context of the clientele they serve, organizational factors, and supervision.

Research Questions

The following research questions will be addressed in the current study:

1. What are the overall experiences of entry-level professional counselors working within community mental health settings and their impacts to professional quality of life and wellness?

2. How do entry-level professional counselors working in community mental health settings perceive the impact of client factors on their professional quality of life and wellness?
3. How do entry-level professional counselors working in community mental health settings perceive the impact of organizational factors on their professional quality of life and wellness?
4. How do entry-level professional counselors working in community mental health settings perceive the impact of personal factors on their professional quality of life and wellness?
5. How do entry-level professional counselors experience developmental critical incidents within the setting of CMH?

Need for the Study

Wellness is a cornerstone of the counseling profession (Myers, 1991; Myers, 1992; Myers & Sweeney, 2008) yet there is limited research regarding the experiences of entry-level professional counselors that may impact wellness. Exploring wellness and impairment with entry-level professional counselors is critical in maintaining our professional identity and establishing standards that fit with the developmental and strengths based philosophy of counseling. It is clear that the risks for impairment are higher for counselors working in the CMH setting (Acker, 2010; Lawson & Myers, 2011; Lawson, 2007; Lent & Schwartz, 2012; Randolph, 2010; Roper-Ericson, 2002; Sprang et al., 2007), and this especially holds true for entry-level professional counselors (Farber, 1985; Lawson & Myers, 2011; Pearlman & MacIain, 1995; Sprang et al., 2007). Yet

researchers have not explored what factors may contribute to wellness or impairment for entry-level professional counselors (Lawson & Myers, 2011; Randolph, 2010) within CMH settings.

Findings from this study have the potential to inform multiple areas within the counseling field including counselor education, counselor supervision and organizational policy. An increased understanding of what entry-level professional counselors are experiencing may help educators, supervisors and organizations promote greater wellness and mitigate impairment. For example, information gained from this examination may provide counselor educators with ways to effectively prepare counselors-in-training to better manage the difficult scenarios they will likely encounter. Supervisors of entry-level professional counselors may find useful information regarding effective supervision interventions that help to protect counselor wellness. CMH organizations may become more aware of how the work that CMH counselors do may have a lasting impact on job performance and ultimately client care. The researcher hopes to establish a base of knowledge that will inform further research with this group of professionals. This study is a first step in establishing a research agenda that will allow for future studies to examine additional variables and experiences of entry-level counselors and those that prepare them for practice through education and supervision.

Definitions of Terms

For the purposes of this study, several terms are defined. They are as follows:

Entry-level professional counselor refers to a counselor that has graduated with a Master's degree in mental health counseling and has a minimum of one year and no more

than two years of postgraduate practice and actively working toward an independent license.

Community Mental Health Setting (CMH) refers to a practice setting that provides counseling related services in a public sector organization or privately owned organization serving the general public in conjunction with government or state funded programs that is considered to have a mission or purpose of serving those that are experiencing mental health related needs. The organization may be nonprofit or for profit. This excludes those in school settings, university settings or in private practice offices.

Wellness is “a way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community. Ideally, it is the optimum state of health and well-being that each individual is capable of achieving” Myers et al., 2000, p. 252).

Impairment “...occurs when there is a significant negative impact on a counselor’s professional functioning which compromises client care or poses the potential for harm to the client” (Lawson & Venart, 2005).

Supervision “is an intervention that is provided by a senior member of a profession to a junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the junior member(s), monitoring the quality of professional services offered to the clients she, he, or they see(s), and serving as a gatekeeper of those who are to enter the particular profession” (Bernard & Goodyear, 1998).

Counselors-in-Training (CITs) refers to counselors who are currently classified as students in a counselor education program.

Professional Licensure refers to the credential granted to counselors who meet requirements set forth by a state licensing body. For the purposes of this study the credentials directed by the state of North Carolina are used.

Licensed Professional Counselor Associate (LPCA) is a limited license designation that requires additional clinical experience under the supervision of an approved supervisor.

Licensed Professional Counselor (LPC) is the full licensure granted to those who have met requirements for an independent license.

Licensed Professional Counselor Supervisor (LPCS) is the credential attributed to advanced counselors who meet requirements for supervision of LPCA licensees.

Council for Accreditation of Counseling and Related Educational Programs (CACREP) is the accrediting organization which reviews and accredits university programs within the counseling field. These include master's and doctoral degrees.

Brief Overview

This study is organized by five chapters. In Chapter 1 a general rationale was given related to the need for a study of entry-level professional counselor experiences within the context of CMH and the impact on counselor wellness. Important terms were defined and research questions were posed. In Chapter 2 a review of literature related to entry-level professional counselors, CMH settings, supervision, and wellness is given in order to further emphasize the need for the study. Chapter 3 includes research questions

and expectations along with explanation of the qualitative methodology used. In Chapter 4 the results of the study are presented. Finally, in Chapter 5, a discussion of the findings and implications from the study is presented. Limitations and needs for further research are discussed. In Chapter 5, the author will address implications of the study and how the information gained may be applied to counselor preparation, supervision and practice.

CHAPTER II

REVIEW OF THE RELATED LITERATURE

Introduction

The potential struggles of entry-level professional counselors working in community mental health settings were discussed in Chapter I. Concepts identified as impacting entry-level counselors included newness to the field, community setting, wellness, impairment and supervision were presented. In the following chapter, the identified needs of entry-level professional counselors specifically within the context of community settings will be further identified. Supporting literature upon which the current study is based will be explored.

Entry-Level Professional Counselors

Entry-level counselors are a unique population with limited attention in the literature. This section will introduce the literature regarding entry-level counselors including the most appropriate terminology to identify this group. In addition, counselor development and supervision concepts are highlighted to show expectations and differences between counseling students and entry-level professionals. A review of literature will determine that this specific group of counselors deserves attention and consideration specifically within the context of their work setting.

Counselors entering the field from their graduate programs face unique challenges that may impact their wellness and ability to provide quality services to their clients.

Furthermore, entry-level professional counselors working in the setting of community mental health (CMH) organizations may be at an even greater risk of deficits in wellness (Lawson & Myers, 2011; Lawson, 2007; Lent & Schwartz, 2012; Randolph, 2010). It appears that entry-level professional counselors who have the least amount of experience are set up to work with clients who present with the most severe needs (Pearlman & MacIlan, 1995; Wachter Morris & Barrio Minton, 2012). This scenario creates a potential for entry-level professional counselor impairment and ethical concerns regarding client welfare (Lawson & Venart, 2005).

Indeed, researchers have concluded that counselors with less experience tend to score higher on measures of burnout and trauma (Farber, 1985; Lent & Schwartz, 2012; Pearlman & MacIlan, 1995; Sprang, Clark & Whitt-Woosley, 2007). Despite this conclusion, researchers have not yet examined adequately the experiences of entry-level professional counselors that may provide insights into this finding (Borders & Brown, 2005; Freadling & Foss-Kelly, 2014; Lawson, 2007; Lawson & Myers, 2011; Mobley, 2004). Even across the significant amount of literature based on counselor burnout and wellness, entry-level professional counselors, and the unique experiences and stressors related to potential impairment, have not been studied (Lawson & Myers, 2011; Lawson, 2007; Lenz & Schwartz, 2012; Randolph, 2010). Furthermore, the work setting of professional counselors (e.g. school, university, community, private practice) has not been considered sufficiently (Borders & Usher, 1992; Fall & Sutton, 2003; Freadling & Foss-Kelly, 2014). This is particularly true for the setting of community mental health agencies.

Given the scarcity of knowledge concerning entry-level professional counselors it is beneficial to explore experiences that might impact these professionals including their level of experience, setting of practice and related supervision experiences. Entry-level professional counselors face unique challenges that deserve attention from researchers, training programs, and organizations as well as supervisors who provide guidance and ongoing support.

A description of entry-level counselors is provided in this section. Challenges related to basic terminology in the discussion of this unique population are identified. Literature related to the needs and experiences of entry-level counselors is presented along with a discussion of how this research has been inclusive of student counselors but not entry-level professional counselors. This section also will include a discussion of counselor development and potential needs for counselors transitioning from the school environment into the work environment with supervision as the proposed mediating experience. The particular setting of community mental health agencies will be addressed. A summary integrating the current literature with the needs of entry-level counselors will be presented.

Challenges in Defining the Entry-Level Professional Counselor

Limited standard terminology exists in the counseling literature referring to counselors working professionally following graduation and maintaining requirements toward an independent license. Fall and Sutton (2003) validated that there is sparse research focusing on counselors in the early years of their practicing careers. This further obstructs the clarity of appropriate labels with which to effectively discuss this

population. A few authors have referred to this group as *entry-level counselors* (Fall & Sutton, 2003; Magnuson, 2002). Others have defined this population as *pre-licensed counselors* (Magnuson, Norem & Wilcoxon, 2000) or *new professional counselors* (Freadling & Foss-Kelly, 2014; Moriss & Minton, 2012). Licensure boards across states use different terms to identify entry-level professional counselors such as provisional counselor, conditionally licensed counselor, counselor associate and additional others (Fall & Sutton, 2003). The term pre-licensed does not seem wholly fitting as many states issue post-graduate counselors a form of restricted or limited licensure while working toward a full independent license. The terms new counselor or novice counselor have primarily been used in the literature to identify beginning counseling students or counselors-in-training (CITs; e.g., Howard, Inman & Altman, 2006; Skovholt & Rønnestad, 2003).

For the purpose of the current study and associated literature review, the term *entry-level counselor* will be the primary focus. This will assist in differentiating between CITs and newly practicing professional counselors who have entered the field of counseling and are practicing in a predominantly independent manner, but are receiving required post-graduate supervision. In addition to being clearer terminology, it will be helpful to identify the experiential differences and similarities between CITs and entry-level professional counselors.

Distinguishing CITs from Entry-Level Counselors. A counselor-in-training (CIT) is typically described as a counselor that is presently enrolled in a graduate program and has extremely limited experiences with formal client-therapist interactions

(Lenz, Sangganjanavanich, Balkin, Oliver, & Smith, 2012). The focus for counseling students has been identified as learning and developing basic counseling skills while under the direction of instructors and supervisors (Borders & Brown, 2005). CITs generally have the new experiences of their first clinical practicum and their first internship placement in the field but all under the premise of formal training. Multiple counselor development models have established the expectation that CITs likely experience a great deal of anxiety and confusion regarding their skill level and role as counselors (Howard, Inman & Altman, 2006; Lent et al., 2006; Skovholt & McCarthy, 1998; Skovholt & Trotter-Mathison, 2011; Woodside, Oberman, Cole & Carruth, 2007). These significant moments of learning that propel counselors toward new growth and expertise have been identified as critical incidents (CIs: Heppner & Roehlke, 1984; Howard et al., 2006; Morrisette, 1996; Skovholt & McCarthy, 1988). Faculty and supervisors guide CITs in navigating CIs in order to develop competence in clinical skills as well as counselor self-awareness and other developmental tasks (Morrisette, 1996; Howard et al., 2006).

CITs have the task of learning not only theoretical and academic content but also new ambiguous counseling skills (i.e., microskills, crisis management, personal process: Howard et al., 2006; Skovholt & Rønnestad, 2003). Understanding the experiences of CITs may be helpful in further exploring the transition of CITs into the context of professional work settings as entry-level professionals. Several studies have been dedicated to exploring the needs and experiences of CITs along with suggestions for supervisors and faculty that assist in their development as counselors (e.g. Bischoff,

Barton, Thober, & Hawley, 2002; Furr & Carroll, 2003; Lee, Eppler, Kendal & Latty, 2001; Skovholt & Rønnestad, 2006). Conversely, we know very little regarding the learning and ongoing development of counselors beyond the formal training years (Borders & Brown, 2005; Skovolt & Trotter-Mathison, 2011).

Counselor development and supervision. An understanding of the development of counselors has been a salient discussion throughout the literature for decades (Borders & Brown, 2005; Skovholt & McCarthy, 1988; Skovholt & Trotter-Mathison, 2011). The identification that counselors move through multiple stages or phases of development in reaction to their experiences has become a central tenet in the field of counseling primarily identified as being facilitated in clinical supervision (Borders & Brown, 2005; Borders & Usher, 1992; Loganbill et al., 1982; Worthington, 1987). Much of the literature related to counselor development has been contextualized within the supervision process. A preliminary overview of concepts related to counselor development will be helpful at this point to consider what unique developmental experiences may apply to entry-level counselors.

Several themes in counselor development have emerged throughout the literature. These include the commonly reported experiences of developing professional identity, self-awareness, personal reactions and a sense of competency (Heppner & Roehlke, 1984; Howard et al., 2006; Skovholt & Rønnestad, 2003). Researchers have expanded upon these common critical incidents (CIs) through qualitative study (Howard et al., 2006). Based on previous research, Howard et al. (2006) identified that CITs experienced CIs related to 5 overarching themes: (a) personal reactions, (b) philosophy of counseling,

(c) competence, (d) professional identity and (e) supervision. Counselors experience these CIs in different ways dependent upon their developmental levels (Blocher, 1983; Borders & Brown, 2005; Heppner & Roehlke, 1984; Loganbill et al., 1982; Stoltenberg, 1981; Welfare & Borders, 2010). Counselor development is not a static achievement; rather it is a life-span process (Borders & Brown, 2005) and perhaps a cyclical movement in and out of developmental stages at increasingly greater heights of complexity (Loganbill et al., 1982). Similarly to CITs, entry-level counselors may experience a comparable developmental process.

Personal reactions. The experience of having a personal reaction to client issues has been discussed in the literature as transference or countertransference (Pearlman & Saakvitne, 1995). Furthermore, the potential reactions to counseling work have been noted as experiences of vicarious trauma and secondary traumatic stress (Figley, 1995; McCann & Pearlman, 1990; Newell & MacNeil, 2010). Skovholt (2001) noted that this natural experience of regulating emotional reactions to clients could be called the “Cycle of Caring”. This involves managing emotional boundaries and learning to process data at quick rates to maintain the therapeutic relationship. It may be that the balance of reacting to client issues with empathy and attachment and then managing the boundaries of separation contributes to a sense of burnout (Skovholt & Rønnestad, 2003; Skovholt, 2001). A lack of professional experience working with ambiguous clinical issues can lead to CITs feeling overwhelmed and less effective (Howard et al., 2006; Skovholt & Rønnestad, 2003). This finding is consistent with other reports that suggest a significant negative relationship between burnout and wellness for counselors beyond training

(Lawson & Myers, 2011; Pearlman & MacIlan, 1995; Sprang, Clark & Whitt-Woosley, 2007). Anxiety that leads to self-focus rather than self-awareness can lead to feelings of incompetence (Skovholt & Rønnestad, 2003; Stoltenberg, 1993). Self-awareness has been noted as a struggle that CITs experience across all levels of training and experience (Heppner & Roehlke, 1984; Loganbill et al., 1982; Skovholt & Rønnestad, 2003; Stoltenberg, 1993).

Counseling philosophy. Beyond personal reactions, CITs have the task of understanding theoretical and philosophical components of counseling (Heppner & Roehlke, 1984; Howard et al., 2006; Loganbill et al., 1982; Skovholt & Ronestad, 2003; Stoltenberg, 1993). It is reasonable that CITs continue to have a self-focus and lack of experience initially that limits their ability to integrate theoretical concepts with practice needs (Howard et al., 2006; Loganbill et al., 1982; Skovholt & Rønnestad, 2003; Stoltenberg, 1993). Counselor development therefore includes both an inward experience and practical application (Howard et al., 2006) that contributes to the development of a counselor's conceptual framework (Skovholt & Rønnestad, 2003). Throughout training the framework is challenged by new experiences (Skovholt & Rønnestad, 2003), the prompting of supervisors (Howard et al., 2006; Loganbill et al., 1982) or other expectations. It is through these challenges to a CITs conceptual framework or cognitive schema along with practical client experiences that a true philosophy of counseling or theoretical orientation can develop (Howard et al., 2006; Skovholt & Rønnestad, 2003). Indeed, cognitive complexity has been shown to change among counselors at different levels thus impacting counselor ability to integrate or understand how counseling

philosophy relates to client experiences (Welfare & Borders, 2010). Whereas it is especially difficult for a beginning student to integrate experience and philosophy, counselors do not cease to experience new challenges to their clinical or personal schema upon graduation (Borders & Hamilton Usher, 1992).

Skovholt and Rønnestad (1992) suggested that counselors develop more insight during the middle years of their training due to gaining both information and experience. Borders and Brown (2005) indicated that counselor and supervision developmental models seem to imply that entry-level professional counselors are in stages of confusion. According to Loganbill et al., (1982) the confusion stage represents a period of fluctuation between awareness and a sense of incompetence. During this stage of confusion, either failing to develop counseling philosophy or misapplying counseling theory can lead to ineffective client outcomes, which in turn could lead to an entry-level counselor to question their competence.

Competence. A counselor at any level may experience new feelings of incompetence related to new or changing expectations or domains of practice (Stoltenberg, 2005; Loganbill et al., 1982). Development of counselor competence is not a static stage of development. Competence encompasses a perceived ability to be an effective counselor and feelings of autonomy (Howard et al., 2006; Loganbill et al., 1982; Skovholt & Rønnestad, 2003; Stoltenberg, 1984). This is especially true for CITs and entry-level counselors (Howard et al., 2006; Skovholt & Rønnestad, 2003). When counselors of all levels are able to work through their anxiety and learn to manage their own affect they are better able to focus on the client (Skovholt & Rønnestad, 2003) and

develop a more supportive cognitive and emotional framework to handle ambiguous clinical situations (Howard et al., 2006; Welfare & Borders, 2010). It is this ability to competently integrate personal reactions with professional or appropriate theoretical response that creates a sense of professional identity.

Professional identity. Increasing the complexity of their vulnerability, entry-level professional counselors also have the task of developing a continued professional identity, which has been linked to a greater sense of wellness (Lawson & Myers, 2011). Gibson, Dollarhide, and Moss (2010) noted that professional identity seems linked to a counselor's ability to integrate both skills and attitudes as a professional and as having a place in a professional community. Gibson, Dooley, Kelchner, Moss and Vacchio (2012) also indicated that a sense of competency contributes to a professional identity. Developing and maintaining professional identity may be a challenge for entry-level professional counselors who received limited exposure during formal education to issues of crises, trauma, and other client issues prevalent in CMH settings; as such, they may experience a lack of confidence or readiness to address such issues. Counselors moving through the more advanced developmental integration stages often experience an ability to assimilate professional identity issues and present with a greater cognitive understanding which leads to increased personal and professional confidence (Borders & Brown, 2005; Loganbill et al., 1982).

Howard et al. (2006) identified that over a third of CIs reported related to the category of professional identity. Participants reported additional subcategories related to (a) learning their professional role, (b) simply being new to an environment that included

navigating unfamiliar practical elements of the role, (c) consideration of their satisfaction with the career choice of counseling, and (d) limitations of being trainees rather than fully licensed professionals. Several concerns emerged from this study that relate to entry-level counselors. Developing strong role identification creates a significant amount of anxiety for CITs (Howard et al., 2006; Skovholt & Rønnestad, 1985), therefore it is likely that continuing to develop an understanding of one's professional role in a practice setting is also laden with anxiety. In addition, being new to the context of professional counseling may pose adjustment needs in both practical organizational responsibilities that may not have been addressed in the academic setting along with clinical responsibilities that may include new difficult clientele issues. Howard et al. (2006) reported that CITs indicated some questioning of their career choice during their initial practicum experience. It is possible that once counselors have taken a job and experienced some role confusion that they may also report doubt or uncertainty about their ability to remain in the counseling field. Questioning career choice may also be a response to the initial idealistic or glamorized expectations that some counselors report in the early stages of training (Skovholt & Rønnestad, 2003), which get compared to the counselor's current real experiences that may prove disappointing (e.g., lack of client progress). Indeed, Skovholt and Trotter-Mathison (2011) identified that the early years of professional practice involve many of the above challenges and include seeking validity of their training and preparation, a sense of disillusionment when that is challenged, and an intense exploration of self and new professional environment.

Howard et al. (2006) suggested that limitations of licensure also might contribute to role confusion or feelings of uncertainty regarding their career choice. The example was given of one participant's concern of not being allowed to see many clients in her practicum experience due to not having a license. Her fear was that she would not meet the requirements of contact hours in order to complete the course. It is likely that similar fears exist for entry-level counselors. Entry-level counselors also have limitations on their ability to practice due to licensure laws and the ability to bill or not bill certain third-party payers.

Supervision. Supervision is an intervention that has been linked to all five of the themes noted by Howard et al. (2006). Furthermore, supervision has been offered as a supportive instrument for entry-level professional counselors to maintain wellness and professional identity (Lenz et al., 2012; Lenz & Smith, 2010; Venart, Vassos, & Pitcher-Heft, 2007). Clinical supervision generally takes place face-to-face and is facilitated by a supervisor who is considered a more senior counselor with the goals of skill development, clinical competence, monitoring client welfare, and supervisee self-awareness (Bernard & Goodyear, 2014; 1998; Loganbill et al., 1982; Tromski-Klingshirn & Davis, 2007). Entry-level professional counselors are required to maintain formal supervision during the early years of their professional work. This requirement has been mandated by every state in the U.S. (Bergman, 2013; Borders, 2005; Fall & Sutton, 2003; Goldberg, Dixon & Wolf, 2012; Magnuson, Norem & Wilcoxon, 2000; Sutton, 2002; Wilcoxon & Magnuson, 2002) and is proposed as a helpful contribution to the development and wellness of entry-level professional counselors (Bober & Regehr, 2006;

Cummins, Massey & Jones, 2007; Etherington, 2000; Etherington, 2009; Harrison & Westwood, 2009; Hesse, 2002; Knight, 2004; Lenz & Smith, 2010; Myer & Ponton, 2006; Trippany, Kress & Wilcoxon, 2004; Sexton, 1999; Sommer, 2008; Somer & Walker, 2004; Young & Lambie, 2007).

However, researchers have not yet adequately explored the actual experiences of professional counselors' supervision beyond the context of graduate school (Borders & Hamilton Usher, 1992; Fall & Sutton, 2003; Freadling & Foss-Kelly, 2014; Schultz, Ososkie, Fried, Nelson & Bardos, 2002). Indeed, Borders and Brown (2005) highlighted that most supervision research has been focused on students or on earlier developmental stages and that there is limited information on post degree supervision and counselor development. Understanding these experiences, specifically within the context of CMH settings, may provide important information regarding how supervision impacts entry-level professional counselor wellness and development.

Considering that a counselor may be experiencing a stage of confusion upon graduation (Loganbill et al., 1982) and entering the mental health field in a more independent role, Borders and Brown (2005) suggested that supervisors should have a very active role. They noted that it is at the mid stages of counselor development (i.e., post-graduate vs. early stages of development while still in training) when confusion occurs and supervisors have significant opportunities to assist counselors in understanding how their interactions with clients may be impacting them as a person. Exploring the supervision experiences of entry-level professional counselors in the CMH setting will provide direction for supervisors taking on this challenging role of support.

Supervision has been identified as important in counselor development and the management of CIs but may also be minimized by CITs due to the tendency to have a self-focus and general lack of awareness of the value of supervision (Loganbill et al., 1982; Stoltenberg, 2005). Conversely, CITs may rely too much on a supervisor to direct them during anxiety filled experiences or ambiguous situations in which the CIT has no specific training (Loganbill et al., 1982). In comparison, an entry-level counselor may experience a range of attitudes toward supervision. For instance, entry-level counselors may feel that they do not need a supervisor and may have some resentment toward being required to maintain this relationship (Borders & Brown, 2005; Loganbill et al., 1982). Complicating the supervision relationship is the evaluative nature for both CITs and entry-level counselors (Borders & Brown, 2005). For the CIT, anxiety may center on the lack of knowledge and experience while being evaluated for academic and practical purposes (Skovholt & Rønnestad, 2003). Similarly, entry-level counselors under supervision continue to have a lack of specific experiences and possibly a deficit in specific knowledge related to their new employment (Wachter Morris & Barrio Minton, 2012) but will be evaluated regardless of their deficits.

Furthermore, the concept of evaluation in supervision may have an even greater sense of importance for entry-level counselors in employment settings. Many times supervisors in community mental health settings have the role of both clinical supervisor and administrative supervisor meaning that they make evaluative decisions on a clinical level and report to licensing boards as well as decisions regarding pay and performance (Falvey, 1987; Henderson, 2009; Tromski-Klingshirn & Davis, 2007). Indeed, Tromski-

Klingshirn and Davis found that nearly half of participants in their study were receiving supervision from the same person considered clinical and administrative supervisor. Further, they noted that the majority (82%) of respondents did not indicate that having a supervisor with a dual role was problematic; however, some counselors did report that they experienced a conflict regarding evaluation of performance. Whereas this is a promising result, there has been too little research truly exploring the full impact of supervision on entry-level professional counselors in CMH settings to determine realistic expectations or needs of supervisees or supervisors. Sommer and Cox (2005) reported that respondents in a qualitative study did indicate that there was discomfort with supervision concerning trauma and sexual violence related client issues when the supervisor held the dual role of clinical and administrative supervisor. It does appear that general wisdom in the counseling field has directed us to consider multiple roles in supervision as a potentially ethical compromise (Association for Counselor Education and Supervision; ACES, 1993, 2011; Falvey, 1987; Henderson, 2009; Kaiser, 1997). Despite the recommendation of avoiding this role conflict, the reality may be that entry-level counselors in the context of CMH do not have the financial or schedule flexibility to seek supervision outside of their employment. Furthermore, supervisors placed in the dual role may need support and models to follow in order to maintain effective clinical and administrative roles. In addition, supervision is not only an organizational reality; it is a requirement for licensure (Bergman, 2013).

Researchers have suggested that supervision is also an effective way to manage stressors for counselors (Adams & Riggs, 2008; Bell et al., 2003; Newell & MacNeil,

2010; Pearlman & Saakvitne, 1995; Sommer, 2008; Sommer & Cox, 2005; Trippany et al., 2004). Multiple authors have contributed to conceptual development in the literature regarding possible strategies for reducing trauma responses and impairment for counselors working with these challenging clientele issues (Etherington, 2000; Etherington, 2009; Knight, 2004; Sexton, 1999; Sommer, 2008; Sommer & Cox, 2005; Walker, 2004); however, supervision models have not been researched to empirically validate this prominent suggestion.

Certainly, it is helpful for supervisors to be aware of the stressors that entry-level counselors in CMH settings face. Indeed, counselors with less experience and who work in CMH settings tend to report higher levels of impairment (Lawson & Myers, 2011; Lent & Schwartz, 2012; Randolph, 2010). Despite the lack of research regarding supervision in this setting, some suggestions have included the need for supervisors to be aware of trauma theory, consider both the conscious and unconscious aspects of treatment such as countertransference, and maintain a safe and respectful environment of supervision (Pearlman & Saakvitne, 1995). Sommer and Cox (2005) suggested a frame of reference, which they called “trauma-sensitive supervision” and indicated the importance of considering a strengths-based approach. Further, there was emphasis placed on self-care and wellness. Awareness in supervision is needed to address counselor issues faced in the specific CMH setting.

In this section the challenges of entry-level professional counselors were discussed. The findings of studies regarding CIs for counseling students were related as consistent with developmental models of counselor education and supervision. The

training period for CITs presents with multiple stages and challenges (Loganbill et al., 1982; Skovholt & Rønnestad, 1992; Stoltenberg, 1981). A review of the literature indicated that entry-level professional counselors most likely experience similar CIs in a new employment or practice setting but with even less support or lack of guidance (Skovholt & Trotter-Mathison, 2011); Similarly to CITs, entry-level counselors likely experience CIs such as personal reactions, competence, developing a philosophy of counseling, professional identity, and supervision requirements during their new professional experiences outside of the formal training environment (Furr & Carroll, 2003; Howard et al., 2006; Skovholt & Rønnestad, 2003; Heppner & Roehlke, 1984). These experiences lead to anxiety and confusion along with potential for great learning (Howard et al., 2006; Skovholt & Rønnestad, 2003; Heppner & Roehlke, 1984). In addition, considering the context in which entry-level counselors are practicing may further clarify how the various critical incidents impact the developing counselor (Borders & Hamilton Usher, 1992; Fall & Sutton, 2003). Furthermore, supervision has been suggested as a primary way to offer support and guidance to both CITs and entry-level professional counselors. It has been suggested that organizations should present a sensitivity and awareness of impairment and wellness for counselors in CMH settings (Schultz et al., 2002; West, 2010). The following section will address the specific challenges faced by counselors in the CMH context including organizational factors and clientele-related challenges.

Community Mental Health Settings

It is clear that the CMH setting is associated with specific challenges for entry-level counselors (Freadling & Foss-Kelly, 2014; Lawson & Myers, 2011; Lent & Schwartz, 2012). The concerns related to CMH settings, including a brief history of CMH settings, organizational factors, and clientele are presented in greater detail in this section. In addition, the importance of understanding the unique setting of CMH related to entry-level professional counselors is addressed. Issues of wellness and impairment are introduced in the context of CMH settings and are covered at length in a following section.

Consideration of the work settings of counselors seems likely to have implications regarding experiences of wellness and impairment. Over 115,080 mental health counselors are employed in the U.S. with a great majority of them working in settings other than private practice or physician's offices (U.S. Bureau of Labor Statistics, 2012). However, work settings of counselors have been given limited attention in research literature as well as conceptual literature (Lent & Schwartz, 2012). Counselors in CMH agency settings tend to report higher levels of burnout and other deficits to wellness than counselors in private practice or university settings (Lawson & Myers, 2011; Lawson, 2007; Lent & Schwartz, 2012; Randolph, 2010). Entry-level counselors in CMH must balance both organizational factors such as public funding, limited resources or outcome-based practices (Acker, 2010; Barak, Nissly & Levin, 2001; Bell et al., 2003; Lawson & Myers, 2011 Maslach & Leiter, 1997) along with a more challenging clientele (Briere & Jordan, 2004; Lindhorst, Macy & Nurius, 2005). This is especially the case for entry-

level professional counselors (Farber, 1985; Freadling & Foss-Kelly, 2014; Lawson & Myers, 2011; Lent & Schwartz, 2012; Pearlman & MacIan, 1995; Sprang, Clark & Whitt-Woosley, 2007). Considering the above referenced counselor development issues, entry-level professional counselors likely experience a great deal of confusion regarding the need to integrate new information within the CMH setting. Researchers have established that the setting of CMH brings a higher risk of impairment for counselors (Lawson, 2007; Lawson & Myers, 2011; Lent & Schwartz, 2012; Randolph, 2010; Sprang et al., 2007).

This section includes a discussion of the history of CMH, organizational factors and challenging client concerns faced by counselors in the CMH setting. Specifically, the potential impacts that entry-level counselors face are included. An introduction into wellness and impairment related to CMH is given in this section; however, a more detailed discussion of these concepts is explored further in the chapter.

History of CMH

Mental health care has become common in our society through private counseling centers, private hospitals and public mental health centers. However, this was not always the situation. Whereas this is not meant to be a thorough history of CMH, a basic understanding of the history and development of CMH will be beneficial. (For a more in depth review of the history of CMH see Cutler et al., 2003 and Murphy & Rigg, 2014). Community mental health has changed significantly over the past 50 years (Cutler, Bevilacqua and McFarland, 2003; Greenlley, 1992; Rosenheck, 2000). Through the mid twentieth century most individuals who experienced symptoms of mental illness were

relegated to institutions such as state hospitals (Cutler et al., 2003) unless they were able to find suitable private care (Murphy & Rigg, 2014). In 1963, the Kennedy Administration passed the Community Mental Health Centers Construction Act (Cutler et al., 2003), which later became the Community Mental Health Act (CMHA; Murphy & Rigg, 2014). The philosophy of the CMHA was that individuals should be treated within their own community rather than in institutions (Murphy & Rigg, 2014). When the CMHA was passed in 1963, this represented a shift in the mental health system toward publicly funded community-based services to meet the needs of the mentally ill (Cutler et al., 2003; Greenley, 1992; Murphy & Rigg, 2014; Rosenheck, 2000). Furthermore, the underlying principles of the CMHA were toward inclusion of those suffering from mental illness to have a voice in their own care. This meant that individuals who were now less likely to be institutionalized should fully participate in their own care (Murphy & Rigg, 2014). This underlying philosophy seems to reflect much of the underlying person-centered philosophy of counselors. Since 1963 many amendments have been made to the original CMHA including the addition of alcohol and drug abuse services as well as mental health services for children (Cutler et al., 2003). Various models and community programs have also developed out of the CMHA vision (Cutler et al., 2003).

Whereas the CMHA was to be a law that encompassed services to the mentally ill in communities, the funding did not necessarily follow. Indeed, funding issues went through multiple presidential administrations before being implemented (Cutler et al., 2003). Funding changes continue even today and are important factors impacting the service delivery of mental health providers (Murphy & Rigg, 2014). It was the funding

and overall management of these services that eventually created some problems with the system of care (Greenley, 1992). Mental health funding also is deeply impacted by politics. For instance, in the 1980s the Reagan administration cut the CMHC funding completely only leaving some distribution of funds in the form of block grants (Cutler et al., 2003). This resulted in states finding ways to utilize the Medicaid model to provide mental health services and this, in turn, resulted in adopting a managed care model of mental health service delivery (Cutler et al., 2003). Managed care has the large goal of providing efficient and affordable care to the masses (Acker, 2010). Managed care in CMH has meant that counselors and other mental health providers have had to learn to treat severe mental illness with limited financial resources as well increased administrative burden (Isett et al., 2009). These challenges unique to CMH settings are discussed further below.

Transition of Entry-Level Counselors to CMH Workforce

Counselors transitioning beyond graduate school programs may be more likely to seek employment in community mental health settings rather than private settings (Freadling & Foss-Kelly, 2014; Randolph, 2010). This may be in part because of employment benefits such as set salary, health care benefits, paid time off, and paid supervision toward licensure. Another possibility is that new graduates face different regulations regarding their licensure. All states require supervised practice in some form for varying time periods following graduation from a counseling program (Bergman, 2013; Borders, 2005; Borders, Cashwell & Rotter, 1995; Fall & Sutton, 2003; Magnuson et al., 2000; Sutton, 2002; Wilcoxon & Magnuson, 2002). Having a limited licensure

poses challenges for entry-level counseling professionals regarding the type of clientele that they are allowed to bill for through third-party insurance companies or state-funded mental health programs. Community agencies tend to have more flexibility regarding licensure status of their employees and at times are able to bill for services under more senior clinicians or bill as an agency rather than on an individual practitioner level. This means that entry-level counselors seeking work are likely limited in their options for employment and may find that they can only be hired at community mental health agencies rather than more desirable private practice settings.

Community settings tend to serve clients with higher risk levels of lethality, trauma experiences, crises, and more pervasive mental disorders (Acker, 2004; Lawson & Myers, 2011; Isett et al., 2009; Sprang et al., 2007; Walsh & Walsh, 2002). These more complex client issues may be a significant challenge to an entry-level professional counselor. Researchers have established that the community agency setting is associated with higher reports of counselor burnout and impairment (Lawson, 2007; Lawson & Myers, 2011; Lent & Schwartz, 2012; Sprang et al., 2007; Randolph, 2010), a topic discussed at length later in this chapter. It appears that professional counselors who have the least amount of experience are set up to work with clients who present with the most severe needs (Pearlman & MacIain, 1995; Wachter Morris & Barrio Minton, 2012). This scenario creates a potential for entry-level professional counselor impairment and ethical concerns regarding client welfare (Lawson & Venart, 2005). Despite this possibility, researchers have not adequately examined the work setting experiences of entry-level

professional counselors that may provide insights into the needs to this group of counselors (Freadling & Foss-Kelly, 2014; Lent & Schwartz, 2012).

Benefits of CMH setting for entry-level counselors. Although agency counselors face many challenges it is also important to discuss the benefits or reasons that many counselors choose this setting. Counselors may enjoy the variety in client populations served through the agency setting. Some agencies may also specialize in specific populations that are of interest to certain counselors such as domestic violence survivors, sexual abuse and assault victims, or developmental disabilities. Counselors usually have some guarantee to a base salary and benefits such as affordable group health care policies. This may be in part due to the availability of public funding. Furthermore, positions may be more readily available in the CMH setting as turnover of staff is high. There may be a lower sense of isolation when working in an agency with other practitioners providing some social and professional support. One significant draw for recent graduates of counselor education programs may be that of guaranteed supervision toward full licensure at no additional cost. In addition, access to clients and continuous referrals sources offers entry-level counselors the ability to gain direct client contact hours with limited challenges. The access to the clients may be unlimited, however the client needs may present as challenging to entry-level counselors.

Organizational Factors

Several organizational factors in CMH agencies may influence entry-level professional counselors' experience of wellness. (Bell et al., 2003; Lawson & Myers, 2011; Lent & Schwartz, 2012). These factors include managed care issues, funding

restraints, limited resources, and significant paperwork (Acker, 2010; Isett et al., 2009). Many of these unique organizational challenges are not covered in depth in traditional counselor training programs leaving entry-level professional counselors unprepared (Skovholt & Rønnestad, 2003). Particularly in a nonprofit setting, resources may be limited (Lent & Schwartz, 2012; Sprang et al., 2007), and additional responsibilities or pressures of reporting success in client care programs may obstruct counselor practice and autonomy (Acker, 2004; 2010; Lawson & Venart, 2005). These demands are especially troubling for counselors who are transitioning into professional practice. Interestingly, counselors tend to indicate that it is not client factors that they associate with burnout or stress as much as with workplace issues such as organizational pressures and caseload size (Schauben & Frazier, 1995; Stamm, 1997).

Counselors in the CMH setting must now adhere to guidelines of practice that do not necessarily take into account best practice for client care but rather focus on financial limitations or outcome measurements with the goal being low-cost and efficient care for those with severe mental illness (Acker, 2010; Acker, 2004; Cohen, 2003; Isett et al., 2009; Scheid, 2003). Counselors in the community sector may be especially vulnerable to the effects of managed care (Acker, 2010; 2004) and must satisfy a more stringent need to meet demands of compliance and accreditation regulations within their organizations rather than focus on client care (Lent & Schwartz, 2012). For example, CMH counselors may be required to follow more stringent documentation or reporting measures than the private practice or school setting. This has been referred to as administrative burden (Isett et al., 2009). CMH counselors may be asked to utilize specific treatment modalities as

standardized by their state, such as family preservation or home-based counseling, thus limiting their sense of autonomy (Isett et al., 2009; Lawson, 2005). Unique concerns such as funding restraints and limited resources can impact counselors' ability to serve clients effectively (DeStefano, Clark & Potter, 2005).

The political nature of CMH cannot be ignored. With this political and economic driven policy making, the current mental health system has in many ways become one of reaction and crisis response rather than one of prevention and treatment (Bloom and Farragher, 2011). A short-term view of health care is often taken with little to no attention placed on prevention. As covered above, CMH within its history and development has certainly shaped the current delivery system (Rosenheck, 2000). Severe mental illness is expensive and consists of systemic issues such as deinstitutionalization, pervasive substance abuse, homelessness, social welfare policy, and access to health care (Isett et al., 2009; Rosenheck, 2000). Severe mental illness and various treatments and responses in CMH have relied on support and proposed solutions from managed care in an attempt to more effectively manage the complexities of care and cost (Isett et al., 2009; Rosenheck, 2000).

Acker (2010) noted that the goal of managed care "is to provide efficient quality care at a lower cost than offered in the fee-for-service professional community" (p. 591). Bolen and Hall (2007) discussed the need for new skills in technology in the current health care field. They noted responsibilities such as documentation and additional paperwork requirements. Another important consideration is that managed care requires professionals to think about how they manage services to be profitable (Bolen & Hall,

2007). Further complexity may be present dependent upon the status of an organization as nonprofit or for profit. Nonprofit organizations may require even more accountability to governing bodies whereas for profit organization may face pressure to deliver profits to stakeholders (Williams & Taylor, 2013). Packard (2010) identified that management of resources and business performance within human service organizations is a complex task given the balance of client care, stakeholder demands and business strategy.

Challenging Clientele

Given that CMH agencies are likely to serve a client population with more limited resources it is possible that this setting attracts a higher number of clients with greater suicide or lethality risks, severe mental illness, and clients with a high level of trauma (Acker, 2010; Gaal, 2009; Sprang et al., 2007; Young & Lambie, 2007). Caseload factors such as a greater number of high-risk clients (e.g., suicidal ideation and patterns, self-injurious; domestic violence or other lethality potential, co-morbidity) and those with more pervasive mental health problems have been related to increases in counselor distress (Acker, 2004; Lawson & Myers, 2011; Isett et al., 2009; Walsh & Walsh, 2002). Caseloads with greater numbers of clients with victimization or violent or human-induced trauma may be associated with a greater risk for Compassion Fatigue (CF) and Secondary Traumatic Stress (STS: Creamer & Liddle, 2005; Cunningham, 2003). Exposure to interpersonal trauma could potentially lead to several forms of impairment such as burnout, compassion fatigue, vicarious trauma, and secondary traumatic stress (Newell & MacNeil, 2010; Stamm, 2010). These specific impairment concerns will be expanded upon in a following section.

Entry-level professional counselors may have limited exposure and training to adequately address the needs of this population resulting in potential deficits in counselor self-efficacy and, as a consequence, may jeopardize client welfare (Barrio Minton & Pease-Carter, 2011; Gibson, Dollarhide & Moss, 2010; Wachter Morris & Barrio Minton, 2012). Often, counselors in community agencies are asked to provide services that at times look very different than what they were trained for through counselor education programs (Kitzrow, 2002; Roach & Young, 2007). For instance, many mental health practitioners, including counselors, are forced to work under a medical model or a disease model rather than one that encourages recovery and long-term healing (Bloom & Farragher 2011). In theory alone, this may be a very different understanding of client conceptualization when compared to the strengths-based counseling view of wellness and holistic oriented perspectives of client issues.

Interpersonal trauma or trauma that is caused by human interaction (e.g., sexual trauma, intimate partner violence, rape etc.) is prevalent and impacts nearly all CMH counselors (Trippany et al., 2004). For instance, sexual trauma, which includes childhood sexual abuse (Briere & Elliot, 2004; Lidhorst, Macy & Nurius, 2005), rape and sexual assault, is highly prevalent among clients in CMH settings. Rates of CSA have been found to be as high as 35% for women and 20% for men (Briere & Elliot, 2003; Finkelhor, Hotaling, Lewis & Smith, 2004). Rape statistics have been reported as high as 20% for women (Black et al., 2011; Tjaden & Thomas, 2000). Symptoms experienced by clients with a history of trauma have been reported to include such difficult counseling

issues as post-traumatic stress disorder (PTSD), borderline personality disorder, interpersonal conflicts, anxiety, and severe depression (Briere & Elliot, 2003).

Intimate partner violence (IPV), or domestic violence, is another stressful and high-empathy concern that counselors often address in CMH practice. Incidence of IPV is reported to occur at the rate of at least 25% with an estimated 1.3 million women as victims (Black et al., 2011; Tjaden & Thoennes, 2000; Centers for Disease Control and Prevention, 2003). It is estimated that only one quarter of physical assaults in intimate relationships is reported to law enforcement (Tjaden & Thoennes, 2000; United States Department of Justice, 2003). Victims of IPV may seek assistance from a CMH agency thus necessitating a counselor to address safety and trauma in response to these difficult situations (Briere & Elliot, 2004; Lidhorst, Macy & Nurius, 2005).

Counselors in CMH settings also may be faced with issues of client suicide. Suicide was reported as the 3rd leading cause of death among individuals aged 15 – 24 (Arias, Anderson, Kung, Murphy & Kochanek, 2003). In spite of the prevalence of lethality issues in society, entry-level professional counselors may not have the support or skills needed to effectively handle these crises presented by clients (Barrio Minton & Pease-Carter, 2011; McGlothlin, Rainey & Kindssvatter, 2005; Wachter Morris & Barrio Minton, 2012). It is clear from past research that counselors reported significant stress when dealing with this type of client issue (Bonnar & McGee, 1977; Granello, 2010; Hendin, Lipschitz, Matsberger, Haas & Wynecoop, 2000).

In this section the history of the CMHA of 1963 and the resulting organizational factors and clientele issues were discussed. These challenges included an increased

administrative burden on counselors, working within a medical model and increased business related responsibilities. Furthermore, the challenges of working with severe mental illness issues such as increased lethality and crisis, IPV, trauma were explored.

Given the documented prevalence and complexity of client issues presented in a CMH counseling agencies, it seems likely that counselors, especially entry-level professional counselors, are at risk for some mental or emotional disturbances that may impact their wellness (Lawson & Myers, 2011; Sprang, Clark & Whitt-Woosley, 2007). Indeed, counselors report disruption in wellness related to caseload factors (Walsh & Walsh, 2002) such as high-risk clients (Lawson & Myers, 2011), and high-trauma (Schauben & Frazier, 1995; Sprang et al., 2007). Whereas there is limited information regarding counselors entering the workforce and the specific types of jobs and duties taken following graduation, it seems reasonable to assume that the CMH agency settings are where a great number of entry-level professionals enter the field upon completion of graduate work (Randolph, 2010). Most entry-level professional counselors are not in a position to begin a private practice soon after graduation and many will seek professional benefits such as supervision or established caseloads along with expected financial compensations such as health insurance that may be provided by CMH organizations. Understanding the clinical mental health agency environment, and how this environment impacts entry-level professional counselors' experience of wellness, may help establish ways to assist them in successfully navigating potential stressors that will inevitably arise and ultimately, strengthen wellness. The constructs of wellness and impairment, along

with these potential impacts to counselor wellness and impairment, are explored in the following sections.

Wellness and Impairment

Definitions of wellness and impairment are described and explained in this section. A brief review of early models of wellness is presented followed by a more detailed explanation of the two major models of wellness. These models include the Wheel of Wellness and the Indivisible Self Model of Wellness (IS-Wel; Myers & Sweeney, 2004, 2005). Wellness research involving counselor educators, counseling students and professional counselors is described. Impairment constructs including burnout, vicarious traumatization, compassion fatigue and secondary traumatic stress are defined along with professional quality of life. Further, research that specifically addressed wellness and impairment for entry-level counselors in CMH settings is explored.

The construct of wellness has grown to be a central paradigm within the field of counseling (Myers, 1991; Myers, 1992; Myers & Sweeney, 2008). The research in support of wellness counseling has encompassed various population groups including clients, law enforcement workers, counseling students, educators, supervisors and counselors (Myers & Sweeney, 2005; Myers & Sweeney, 2008; Tanigoshi, Kantos & Remley, 2008). However, researchers agree that further research of practicing professional counselor wellness is needed (e.g., Lawson & Myers, 2011; Myers & Sweeney, 2008; Roach & Young, 2007). Some have suggested activities and ways of maintaining wellness (Cummins, Massey, & Jones, 2007; Myer & Ponton, 2006; Young

& Lambie, 2007). Nevertheless, little research has truly examined counselor wellness (Lawson, 2007; Lawson & Myers, 2011; Mobley, 2004). Whereas counselors tend to emphasize wellness concepts it is equally important to understand impairment and how it may manifest for counselors (Lawson, 2007; Lee, Cho, Kissinger, & Ogle, 2010). The converse of wellness has been cited as illness or impairment (Lawson, Venart, Hazler, & Kottler, 2007).

A review of the inter-disciplinary literature on the concepts of wellness and impairment is useful, but beyond the scope of this writing. However, a focus on the literature from the framework of counseling philosophy is imperative. Historical definitions and theoretical principles are invaluable to understanding the importance of researching wellness and ultimately wellness as applied to counselors. Constructs are expanded to explain the factors that have been identified in the literature. Research findings are presented along with rationale and implications of studying counselor wellness. Application is specifically directed toward entry-level counselors within the context of community mental health. Needs for further research are suggested. Definitions and various constructs of impairment are expanded upon later in the chapter.

Wellness Definitions and Models

The counseling profession is built upon years of developmental and wellness-based philosophy (Ivey & Ivey, 1999; Myers, 1992; Sweeney, 2002). Defining the concept of wellness has been an ongoing process. Many authors have attempted to define wellness from multiple perspectives including medical models and psychological models. One of the most cited definitions of wellness is from the World Health Organization

(1958). The dimensions of physical, mental, and social well-being were identified and acknowledgement made that wellness is not only the absence of illness or disease but rather involves a more holistic conceptualization of individuals. Most researchers have at least agreed that wellness is multidimensional and not simply the absence of illness (Roscoe, 2009).

Roscoe (2009) argued that there has been no integrated definition of wellness. However, it could be countered that an integrated definition has been provided through the years of wellness research. Furthermore, a greater need in the counseling literature may be an understanding and consensus of the models of wellness that have become foundational to a definition of wellness. Myers, Sweeney and Witmer (2000) articulated what has become the basis for the most widely researched model of wellness when they stated that wellness is:

A way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community. Ideally, it is the optimum state of health and well-being that each individual is capable of achieving. (p. 252)

This definition was identified with the Wheel of Wellness (Sweeney & Witmer, 1991; Witmer & Sweeney, 1992). The Wheel of Wellness is significant to the counseling literature because it is the first model of wellness based in developmental counseling philosophy (Myers & Sweeney, 2008). This model is presented in more detail below.

Early models of wellness. Dunn (1977), an influential figure in the modern wellness movement (Hattie, Myers and Sweeney, 2004), stated that wellness is “an

integrated method of functioning, which is oriented toward maximizing the potential of which the individual is capable” (p. 4). Dunn’s early definition of wellness also contained evidence that he viewed wellness as integrated and holistic (1977). Dunn (1961) offered a description of wellness in the form of three orbits that identified the human body as energy that had been organized and interrelated.

Hettler (1984), who has been called “the father of the modern wellness movement” (p. 483, Myers & Sweeney, 2008), offered a hexagonal model of wellness that identified areas of functioning as (a) physical, (b) emotional, (c) social, (d) intellectual, (e) occupational, and (f) spiritual. Myers and Sweeney (2008) pointed out this model emphasized optimal physical health rather than a holistic and integrated functioning across factors and across the life span. Travis (1972) presented wellness on a continuum with illness on the opposite end. Travis and Ryan (1988) used a medical model but did acknowledge that wellness is not merely related to a ratio of illness. Attention of the model was toward responsible and healthy lifestyle choices. Similarly, Ardell (1977) promoted responsibility in personal wellness. The Optimal Living Profile developed by Renger, Midyett, Soto Mas, and Erin (2000), is largely based on public health philosophy. Although it appears to offer a good level of integration among factors, it was presented as emphasizing healthy choices and habits as opposed to a model of interrelated factors that make up a well individual. Whereas, earlier models acknowledged some level of integration, none presented with a holistic picture of the complexity of human wellness.

The Wheel of Wellness. The Wheel of Wellness was developed through the study of inter-disciplinary research that identified associated characteristics of health, quality of life, and longevity (Myers & Sweeney, 2005; Myers & Sweeney, 2008). Adlerian Individual Psychology was used to organize the identified components of wellness (Sweeney, 1998). As the model's name implies, the 12 factors of wellness are shown in a wheel as spokes that connect to the Adlerian life tasks of work and leisure, friendship, and love (Myers & Sweeney, 2008). The use of spirituality as the center of the wheel with self-direction leading into the 12 spokes of wellness was noted as integral in understanding the concepts of wellness through Adlerian theory (Dreikurs & Mosak, 1967 as cited in Myers & Sweeney, 2005). To further validate the construct of wellness, this model is inclusive of contextual factors that are seen to influence wellness such as media, government, education and community, along with global factors that impact an individual's well-being (Witmer & Sweeney, 1992).

In order to assess the usefulness and accuracy of the Wheel of Wellness, Witmer, Sweeney, and Myers (1996; 1998) developed the Wellness Evaluation of Lifestyle (WEL). Studies were conducted regularly over several years to examine the psychometric properties of the WEL and to determine if the Wheel of Wellness model was in fact supported (Myers and Sweeney, 2005; Myers & Sweeney, 2008; Hattie, Myers & Sweeney, 2004). The researchers found that the psychometric properties of the WEL were valid and reliable but that the theoretical model of wellness proposed was not supported (Myers & Sweeney, 2005).

Indivisible self model of wellness. Hattie, Myers and Sweeney (2004) conducted a detailed factor analysis of an extensive database of scores from previous versions of the WEL. Through this research the Indivisible Self Model of Wellness (IS-Wel; Myers & Sweeney, 2005) emerged. The developers remained faithful to the use of Adlerian theory to assist in organizing the model (Myers & Sweeney, 2008). The previous analysis distinguished a single higher order factor of overall wellness (Hattie et al., 2004). The researchers indicated that they struggled to understand this in light of the statistical evidence that separated the original theory from the new findings (Myers & Sweeney, 2008). Placed against the underlying Adlerian principles, the concept of a single higher order factor of wellness became clear. Myers and Sweeney (2005; 2008) explained that the higher order factor of wellness is based on Adler's belief that the self is indivisible and cannot be divided into parts.

The five second-order factors that emerged in the research from the original 17 components were explained as the composition of the indivisible self. The second-order factors contained corresponding third-order factors (Hattie et al., 2004; Myers & Sweeney, 2005; Myers & Sweeney, 2008). The identified parts that make up the Indivisible Self are the (a) Creative Self, (b) Coping Self, (c) Social Self, (d) Essential Self, and (e) Physical Self (Myers & Sweeney, 2005). The developers noted that they continued to return to the basis of Adlerian theory to understand the interactions and groupings of the factors (Myers & Sweeney, 2008). Myers and Sweeney (2005) offered detailed descriptions of each of the factors that make up the indivisible self. A brief

review of these will contribute to an understanding of the remaining discussion of wellness and the concepts related to impairment.

The first grouping of the Creative Self combined the third-order factors of (a) Thinking, (b) Emotions, (c) Control, (d) Work and (e) Positive Humor. Myers and Sweeney (2005) noted that Adler believed the Creative Self was “the combination of attributes that each individual forms to make a unique place among others in our social interactions” (p. 34). The authors were clear that each of the third-order factors interacts to form a holistic model of functioning. Interpreting the world through learning, awareness of feelings, expressing needs, laughing, and having meaningful work contributes to high functioning of wellness within the Creative Self (Myers & Sweeney, 2005; Myers & Sweeney, 2008).

Another second-order wellness factor identified by Myers and Sweeney (2005) is the Coping Self. This factor is made up of (a) Leisure, (b) Stress Management, (c) Self-Worth and (d) Realistic Beliefs. It is the Coping Self that helps individuals to respond to life events and overcome potential negative impact (Myers & Sweeney, 2005; Myers & Sweeney, 2008).

The third factor, the Social Self, is comprised of Friendship and Love, which are identified as operating on a continuum and often are not easily defined in terms of activities (Myers & Sweeney, 2005). The developers of the model explained that the Social Self is inclusive of family relationships that support an individual and they identified these supports as primary. It was noted that a positive family experience provides more potential for individual wellness.

The fourth factor grouping is identified as the Essential Self. This factor contains those third-order factors of wellness that seem to contribute to an individual's sense of purpose and meaning. These components include (a) Spirituality, (b) Gender Identity, (c) Cultural Identity, and (d) Self-Care. Myers and Sweeney (2005) acknowledged spirituality as existential while gender and culture act as "...filters through which life experiences are seen..." (p. 34).

The final second-order wellness factor is the Physical Self and includes exercise and nutrition. These factors are important; however previous models of wellness seemed to overemphasize this sphere by focusing on diet and exercise lifestyle changes (Hettler, 1984; Myers & Sweeney, 2005; Myers & Sweeney, 2008).

One unique feature of the IS-Wel model is the inclusion of contextual variables that are acknowledged as having a systemic impact on human wellness (Myers & Sweeney, 2005). The four contexts include (a) Local, (b) Institutional, (c) Global, and (d) Chronometrical. The developers expressed it is not possible to fully understand an individual without considering environmental influences. This specific model is presented here not only because it is well researched but also because of contextual factors that may provide a more multidimensional base for studying counselor wellness in specific environments such as CMH agencies.

Wellness Research

Wellness models have been used in both conceptual discussions as well as empirical research in the counseling field. A review of how wellness has been researched and reported in the counseling literature is critical to understand the ongoing needs in this

area. Myers and Sweeney (2008) provided an excellent summary of wellness counseling research. They focused on ways in which the WEL and 5F-Wel (two instruments that measure wellness) have been used in various studies. Both non-counselor populations and counselor related groups continue to be studied. This review will focus on how the research of the IS-Wel and Wheel of Wellness models has advanced understanding of counselor wellness. Myers and Sweeney (2008) placed studies related to counselors-in-training, counselor educators, and professional counselors in a condensed category. This review will differentiate between the subgroups within this condensed category.

Counselor educators. A significant role has been suggested of counselor educators in promoting and training CITs to make wellness a priority (Hill, 2004; Wester, Trepal & Myers, 2009; Yager & Tovar-Blank, 2007). Only two currently published research studies were found that addressed counselor educator wellness. Wester et al. (2009) reported that Total Wellness scores on the 5F-Wel tended to be higher for counselor educators than the normed scores for the 5F-Wel. The rankings of the second order factors for counselor educators were reported as: (a) Social Self, (b) Creative Self, (c) Essential Self, (d) Coping Self, and (e) Physical Self. The authors noted that this study was exploratory and is only a foundational examination of counselor educator wellness and suggested further research should include qualitative inquiry. Shillingford, Trice-Black and Butler (2013) specifically explored wellness of minority female counselor educators in a qualitative study. Many components of the qualitative results supported findings from Wester et al. (2009) in that social support, self-care, and motivation to excel were cited by respondents as important. Consistent with the IS-Wel (Myers, 2005)

spirituality was noted as a priority in maintaining wellness for this group of counselor educators.

Counseling students. Masters and doctoral level student wellness has been examined (Lambie et al., 2009; Moorehead, Gill, Minton & Myers, 2012; Myers, Mobley & Booth, 2003; Perepiczka & Balkin, 2010; Roach & Young, 2007; Smith, Robinson, & Young, 2007). One consistent finding in studies dedicated to counseling students is the tendency to score higher on wellness measurements than the general public (Lambie et al., 2009; Moorehead et al., 2012; Myers et al., 2003; Perepiczka & Balkin, 2010; Roach & Young, 2007). It has been hypothesized that the more advanced the student, the greater level of wellness reported (Myers et al., 2003). Indeed, Myers et al. did report that doctoral counseling students scored higher on wellness than did master's level students. This seemed to imply the possibility that the more advanced or greater level of experience may help facilitate wellness. However, in contrast, Roach and Young (2007) did not find any significant differences between master's level students at three different points in their training. In addition, Perepiczka and Balkin (2010) investigated the relationship between age, year of study and relationship status of doctoral students in counseling and found no relationship to wellness among these factors. These findings present some interpretive challenges given that each study was looking at different variables and relationships. This does not necessarily lead us to conclude that there is no relationship between level of training or experience upon wellness beyond the formal training environment. For instance, Lambie, Smith and Ieva (2009) found that between 9% and 16% of beginning counseling students scored as clinically distressed. The authors

offered the theory that graduate school adjustment can be difficult and contribute to the explanation of the distress levels. These factors seem important in measuring ego development and wellness at least at on a theoretical level. In addition, Smith et al. (2007) found that over 10% of counseling students indicated psychological distress. Thus, experience and place in education may indeed impact counseling student wellness. The same awareness of adjustment needs should be given to entry-level counselors transitioning from school to work environments.

Professional counselors. Despite the above findings regarding counseling students, the literature addressing the wellness of professional counselors consists mostly of conceptual articles that offer suggestions for increasing counselor self-care (Lawson, 2007; Lawson & Myers, 2011; Myers et al., 2003). Only a handful of published studies that specifically examined professional counselor wellness were found for this review. None of the studies had specifically examined wellness of entry-level professional counselors. Mobley (2004) conducted a dissertation study that examined counselor wellness, but limited his population group to male counselors. He sought to explore how gender role conflict and counselor training related to wellness. He found no significant relationships between wellness and gender issues. In her dissertation study, Martin (2012) examined female professional counselors and the relationship between wellness and role balance with various personal and professional factors. She reported some relationships between multiple roles such as caregiving for dependents and wellness. In addition, she found that age was not a factor among the women counselors as a predictor of wellness however, she did indicate that as experience level of the respondents increased, the

wellness levels increased. Nesweld-Potter et al. (2013) surveyed professional counselors to understand more how counselors define personal and professional wellness and to identify wellness related behaviors. The participants were noted as having consistently reflected the term balance when reporting their definitions of wellness. In addition, the participants seemed to place emphasis on health as the largest category of wellness related behaviors. This consisted of themes related to both emotional health and physical health. Further categories of wellness included relationships and experiences of fun. These categories seem consistent with the Social Self, Physical Self and Coping Self (Myers & Sweeney, 2005).

Lawson and Myers (2011) conducted the most detailed and promising study of wellness for professional counselors to date. They incorporated measurements of wellness, professional quality of life and career sustaining behaviors of professional counselors. Some significant findings related to work setting of counselors included the conclusion that CMH counselors scored higher on impairment measurements and lower on wellness. They also found that there was a positive correlation between counselor caseloads with a high number of trauma survivors and high-risk clients to burnout. Further details of this study are noted below, within the *research addressing wellness and impairment section*, as it is foundational to the current study because the researchers examined wellness and impairment of counselors *and* accounted for work setting of counselors.

Wellness of entry-level counselors. It is apparent that researchers have largely neglected examining wellness among professional counselors. More specifically, there is

no research dedicated to understanding wellness experiences of entry-level professional counselors. Furthermore, the researcher could find only one study examining the work settings of professional counselors within the wellness literature (Randolph, 2010). One additional study that examined general experiences of entry-level counselors was found (Freadling & Foss-Kelly, 2014). Some promising information has been revealed regarding the likelihood that with increased experience comes an increased sense of wellness (Lawson, 2007; Lawson & Myers, 2011; Martin, 2012); however, the experiences of entry-level counselors and wellness within this group have not been examined. Despite the many urgings of seasoned counselor educators and authors toward a focus on wellness, the voice of the entry-level professional counselor has largely been neglected.

With researchers beginning to emphasize the importance of wellness for professional counselors it is also important to examine impairment of counselors. An understanding of impairment may help increase understanding of needs for maintaining counselor competence and the impact of counseling work for counselors. Left unaddressed, excessive degrees of counselor stress and inadequate or ineffective coping interventions may develop into impairment (Lawson & Venart, 2005). In addition, ultimately impairment is a client welfare concern and a lack of wellness or competence on a personal or professional level poses ethical considerations for counselors (ACA, 2014; Kocet, 2005). Throughout the counseling literature, it is clear that counselors value self-care and wellness (Lawson, et al., 2007; Osborn, 2004; Witmer & Young, 1996), but it is less clear how a lack of wellness manifests itself in the counselor population. Similar

to the wellness literature, very little empirical attention has been given to the issue of counselor impairment among entry-level counselors. There continues to be a significant need for research regarding counselors who struggle to find wellness in their professional lives.

Impairment

Sheffield (1998) attempted to provide some direction for the counseling profession related to impairment when he indicated that there was no agreed upon definition of impairment. He suggested that a task force be created in order to develop a definition and to assess the level of need in the profession. In 2003, ACA did form a task force for that very purpose. The task force stated "...therapeutic impairment occurs when there is a significant negative impact on a counselor's professional functioning which compromises client care or poses the potential for harm to the client" (Lawson & Venart, 2005).

The developers included that impairment may occur when there is a mental illness, personal crisis, physical debilitation or substance abuse present for the counselor. They were clear in pointing out that impairment is not an unethical behavior but rather unethical behavior may occur because of the impairment. The task force also noted that impairment is different than stress or distress and that a counselor may experience stress without becoming impaired. Although stress may be a factor in mental illness, personal crisis, physical debilitation, or substance abuse, the task force noted (a) that impairment is different than stress or distress and (b) that a counselor may experience stress without

becoming impaired. However, left unaddressed, excessive degrees of counselor stress and inadequate or ineffective coping interventions may develop into impairment.

Kocet (2006) noted that in the 2005 revision of the ACA Code of Ethics special attention was given to issues of counselor impairment. He implied that acknowledgement of the difficulties that counselors face led to more detail in the standards addressing impairment. Impairment of counselors was directly addressed in the ACA Code of Ethics (2005) and is maintained in the 2014 revisions. The 2014 Code of Ethics states:

Counselors monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when impaired. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until it is determined that they may safely resume their work. Counselors assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted with colleagues or supervisors showing signs of impairment and intervene as appropriate to prevent imminent harm to clients. (ACA, 2014; C.2.g)

The counseling field is becoming more aware of the needs regarding impairment however; research specifically with counselors continues to be sparse. Much of the impairment literature has been presented in related service fields rather than in the counseling field.

Four key components are identified in the literature related to impairment. These include (a) burnout, (b) compassion fatigue, (c) secondary traumatic stress and (d) vicarious trauma. Newell and MacNeil (2010) argued that it is important to distinguish between impairment related to personal or professional burnout versus conditions that may be experienced specifically from human service work. Impairment has been

somewhat arbitrarily split into personal factors and work related factors (Lawson, 2007; Maslach, 2003; Skovholt and Trotter-Mathison, 2011). Lawson (2007) implied that personal variables are based on the counselor's subjective perception of wellness or impairment, whereas professional variables include such things as organizational setting, caseload factors and professional support. Burnout seems to encompass these organizational factors. Potential impairment related more to the nature of counseling work are best represented by compassion fatigue (CF), vicarious trauma (VT), and secondary traumatic stress (STS).

Burnout. Freudenberger (1975), Maslach (1976), and Pines and Maslach (1978) provided a beginning working definition for burnout. This construct has developed over time and has been researched with varied professional fields and workers. It has been noted that burnout is studied largely among individuals working in human services and educational fields (Lee, Baker, Ho Choet al., 2007; Maslach, Schaufeli, & Leiter 2001). Burnout impacts both the physical and emotional well-being of individual workers (Farber, 1985; Rupert & Kent, 2007).

Job burnout is recognized as a phenomenon that occurs over a prolonged period of time rather than in response to a specific event (Maslach et al., 2001; Maslach & Leiter, 2008; Osborn, 2004;). Maslach and her colleagues have consistently presented that job burnout includes three dimensions: (a) exhaustion, (b) cynicism, and (c) sense of inefficacy (Maslach, 2003; Maslach, 1976; Maslach et al., 2001; Maslach & Leiter, 2008). Furthermore, the development of burnout has been more associated with institutional stressors or caseload factors rather than client material (Stamm, 1997). Behavioral

evidence of burnout has been reported as a general detachment or disengagement in one's job as well as missing scheduled appointments (Pines & Maslach, 1978). The definition most cited in the burnout literature refers to Maslach's research and is stated as follows:

Burnout is a prolonged response to chronic emotional and interpersonal stressors on the job, and is defined by the three dimensions of exhaustion, cynicism, and inefficacy. (2003)

Lee et al. (2007) argued that while Maslach's definition is multidimensional at the individual level, they noted that a different definition of burnout might include environmental factors. The construct of burnout historically has been measured using the Maslach Burnout Inventory – Human Services Survey (MBI-HSS; Maslach, Jackson & Leiter, 1996). Lee and colleagues set out to develop a new measurement that could assist in examining burnout specifically with counselors as well as the interaction between the environment and the individual (2007).

To develop the Counselor Burnout Inventory (CBI; 2007), Lee et al. conducted a two-phase factor analysis including exploratory factor analysis and confirmatory factor analysis. This research tool was designed to assess counselors on five dimensions rather than three. The areas addressed in the CBI included (a) exhaustion, (b) negative work environment, (c) devaluing client, (d) incompetence, and (e) deterioration of personal life. The authors emphatically noted that more clarity is needed regarding construct validity in the development of this tool. Taking this research a step further, Lee, Cho, Kissinger, and Ogle (2010) sought to identify clusters or typologies of burnout that included a more distinct picture of how counselors react to potential burnout factors.

They labeled the three clusters as (a) well-adjusted counselors, (b) disconnected counselors, and (c) persevering counselors. Whereas much more research is needed to validate this measurement tool it does provide some insight into the necessity that supervisors and colleagues view each counselor in the context of his or her environment.

Compassion Fatigue. *Compassion Fatigue* (CF) was used by Figley (1995) to indicate a sense of exhaustion related to chronic empathy. CF has been attributed as being the result of observing the suffering of others (Figley, 2002). The symptoms of CF include emotional exhaustion, physical exhaustion, withdrawal, avoidance, and irritability (Figley, 1995). In addition, CF can result in counselors experiencing confusion, a sense of powerlessness, and an inability to remain present with clients (Figley, 2002). Further cognitive symptoms, which counselors may experience, include a decrease in self-esteem, preoccupation with the trauma, feelings of apathy, decreased concentration and thoughts of harm to self or others (Berzoff & Kita, 2010). Similarly to burnout, CF occurs over time rather than as an immediate reaction to stressors (Newell & MacNeil, 2010). Very few studies exist regarding CF with helping professionals (Sprang et al., 2007); rather more research has been conducted using constructs of STS and VT.

Newell and MacNeil (2010) noted that the concepts of CF and STS are often grouped together and may not be the best way to conceptualize the different types of impairment experienced by counselors. The current research is continuing to define these experiences, which will be helpful to develop some consistency (Bride, 2007; Schauben & Frazier, 1995). Stamm (2010) has used the term compassion fatigue to incorporate VT

or STS and the emotional responses related to burnout such as exhaustion, frustration, anger and depression.

Secondary traumatic stress. Much like CF, secondary traumatic stress (STS) refers to an experience associated with observing or hearing about another person's trauma experience (Figley, 1995). STS symptoms have been compared to the experience of post-traumatic stress disorder (PTSD) in that the symptoms are similar and include intrusive thoughts, trauma related memories, insomnia, avoidance and hypervigilance (Newell & MacNeil, 2010). The difference between STS and PTSD is that the counselor does not directly experience the trauma in STS; rather the trauma is experienced directly by the client and experienced secondarily by the counselor (Hernandez, Gangsei & Engstrom, 2007). Whereas CF tends to develop over time, STS may indeed result from a single interaction with a traumatized client (Figley, 1995).

Vicarious trauma. McCann and Pearlman (1990) referred to VT as the various disruptions that counselors experience in their cognitive schemas related to (a) safety, (b) trust, (c) esteem, (d) intimacy and (e) control. STS on the other hand refers to a syndrome with symptoms that appear similar to those of posttraumatic stress disorder (PTSD) and occurs as a result of exposure to trauma experiences of others (Figley, 1995; Stamm, 1999). VT can be understood further using the model of Constructivist Self-Development Theory (CSDT; McCann & Pearlman, 1990). CSDT is a developmental model, which places the experiences related to trauma in both a constructivist and individual context (Pearlman & Saakvitne, 1995). These assumptions of CSDT allow the consideration that individual counselors will experience trauma differently based on their constructed reality

and understanding of the trauma. In addition, the individual framework allows consideration of personality factors, personal experiences and reactions. CSDT posits that a counselor's cognitive framework may be disrupted in five areas: (a) safety, (b) trust, (c) esteem, (d) control, and (e) intimacy. Dunkley and Whelan (2006) suggested that although CSDT is a useful model to understand trauma reactions, one major limitation is that CSDT does not account for potentially positive reactions to trauma. Indeed, posttraumatic growth may occur following a trauma experience (Tedeschi & Calhoun, 2004).

Professional quality of life. Professional Quality of Life brings together positive and negative factors that a counselor might experience. Stamm (2010) has defined *professional quality of life* as the “quality one feels in relation to their work as a helper” (p. 8). The Professional Quality of Life (ProQOL) scale (Stamm, 2009; 2010) is a 30-item measurement, which relies on self-report to assess CS, CF/STS and burnout. Stamm (2010) has reported good construct validity for the ProQOL and has cited over 200 publications using the scale. The ProQOL measures the constructs of Compassion Satisfaction, Burnout and STS. Internal consistency of the ProQOL has been noted as good with alpha reliabilities as follows (Stamm, 2010): Compassion Satisfaction (.88), Burnout (.75), and Secondary Traumatic Stress (.81). These factors are discussed further as related to impairment. The use of such a measurement in research studies may serve to supplement research based on self-report of participants and provide a fuller picture of wellness and impairment of entry-level professional counselors.

Impairment Research

There remains limited research addressing impairment of counselors related to burnout, CF, STS and VT. Nevertheless, some researchers are beginning to focus specifically on trauma work and the reactions of non-counselor helpers. For instance, in a foundational study Pearlman and MacIan (1995) explored the experiences of trauma therapists. They noted that there were significant findings related to the personal trauma history of therapists. In addition, therapists who reported a personal trauma history showed an increase in VT and disruption in cognitive schema if they reported less than two years of professional experience. Other researchers have confirmed that having a history of abuse or trauma predicted STS in domestic violence workers (Slattery & Goodman, 2009) and resulted in a decreased sense of safety and esteem of others in social workers (Cunningham, 2003). In contrast, one earlier study surveyed female psychologists and sexual violence counselors and found no statistically significant differences among respondents who reported a personal history of victimization (Schauben & Frazier, 1995). Bride (2007) specifically looked at master's level social workers' experiences with STS. Respondents reported overall that they experienced low levels of STS symptoms however 40.5 percent of respondents did indicate that they experienced intrusive thoughts about their clients. Similarly, Tehrani (2007) found that over 60% of helping professionals working with trauma expressed negative changes in their beliefs about the world and others.

A higher number of trauma survivors on a counselor's caseload has been related to an increase in VT and other disruptions in cognitive reactions (Bober & Regehr, 2006;

Cunningham, 2003; Iliffe & Steed, 2000; Pearlman & MacIlan, 1995; Schauben & Frazier, 1995; Sprang et al., 2007). Amount of professional experience has also been associated with an increase in disruption of beliefs (Bober & Regehr, 2005; Cunningham, 2003; Pearlman & MacIlan, 1995) as well as an increase in burnout (Sprang et al., 2007; Iliffe & Steed, 2000). As such, entry-level counselors may be at increased risk of impairment such as burnout, CF, STS and VT.

The potential consequences of difficult counseling work should not be taken lightly when considering potential impacts to counselor and client welfare. Although there is limited empirical knowledge concerning the experiences and impacts of wellness and impairment on entry-level counselors in CMH, the scant research (Lawson & Myers, 2011; Lawson, 2007; Lent & Schwartz, 2012; Sprang et al., 2007) available does imply that there is a relationship between these complex constructs. This research is reviewed in next section. One large limitation to most of the studies conducted regarding wellness or impairment of helping professionals is that the researchers included multiple career fields (i.e. social workers, psychologists, counselors, nurses, etc.) as well as differing educational levels (i.e. bachelor's degree, master's degree, doctoral degree). This has created difficulty in understanding how the results directly relate to entry-level counselors as well as differentiating work settings. Furthermore, the experiences and voices of entry-level counselors within CMH settings have remained silent in the literature. A focused study examining master's level professional counselors in a specific work setting as proposed in the current study will provide more consistent results and direction for future research related to this unique group of helpers. The following section

addresses the primary research upon which the proposed study will likely expand to include more specifically entry-level counselors working in the CMH setting.

Research Addressing Wellness and Impairment of Counselors

In this section, research studies that contribute most to the understanding of the relationship between years of experience, wellness, impairment, and work setting of counselors are presented. Similarities and differences among the research are identified and expanded upon to include potential for new understanding. Suggestions for further research are discussed as well. Whereas there are multiple studies that begin to incorporate the specific variables of years of experience, wellness, impairment and CMH setting of counselors, the following studies seem the most informative regarding identifying a relationship between the variables.

Lawson and Myers (2011) provided the richest data yet exploring the needs of counselors related to the constructs of wellness and impairment. Lawson (2007) began looking at professional counselor wellness and impairment but only included a self-report instrument in his study to specifically measure wellness levels. He conducted a national survey study with 501 American Counseling Association (ACA) members. This initial survey included the Career-Sustaining Behaviors Questionnaire (CSBQ; Stevanovic & Rupert, 2004), the Professional Quality of Life Scale-Third Edition-Revised (ProQOL-III-R; Stamm, 2005) and a demographic questionnaire, which also asked about perceived wellness. In a follow up study using a similar survey packet, Lawson and Myers (2011) added the Five Factor Wellness Inventory (5F-Wel). This allowed the researchers to further examine variables impacting counselors.

Both of these studies presented similar demographic results. For instance, both samples were largely women and predominantly Caucasian. In addition, the mean ages of respondents were between 48.8 and 49.9 years. Between 73% and 80% of respondents in both studies reported a Master's degree as their highest level of education. Experience levels of counselors were between 12.3 years and 13.6 years. Respondents in both studies indicated that around 23% were practicing at CMH organizations. Similarities in caseload variables were reported as well. Respondents indicated that their caseloads consisted of between 28.3 and 30.86 clients. Further explanation of the caseload variables showed that roughly 35% of clients on a respondent's caseload had a history of trauma and over 15% of the caseload was actively experiencing some type of crisis such as suicidal ideation, self-injury or other type of danger. Lawson (2007) expanded that CMH counselors reported that more than half of their client caseload could be categorized as having a history of trauma. In addition, the CMH counselors had significantly higher reports of high-risk clients. These simple demographic results indicate clearly that wellness of counselors in the CMH setting is at-risk.

Lawson (2007) and Lawson and Myers (2011) both inquired about wellness. Lawson (2007) presented respondents with a range of wellness on a scale of 1-7 with the categories of well, stressed, distressed or impaired. Respondents self-reported overall that they are well (80.7%). No respondents self-reported that they consider themselves as impaired. Only 4.3% of participants considered themselves to be distressed and 15% reported themselves to be stressed. Interestingly, the respondents did indicate that they had colleagues who they considered impaired. This could indicate that some counselors

lack awareness of their own wellness and impairment or that there is a social desirability impact of self-report of wellness and impairment.

In comparison, Lawson and Myers (2011) administered the 5F-Wel to determine wellness levels of respondents. Not unlike the self-report findings of respondents (Lawson, 2007), the overall majority of respondents indicated that they are well. The mean score of respondents to the 5F-Wel was 84.5 on Total Wellness. In addition, the highest mean score of the five factor scores was Social Self at 92.5 and the lowest mean score on the Physical Self at 78.11. Furthermore, Lawson and Myers clarified that counselors scoring higher on the 5F-Wel tended to have a lower percentage of high-risk clients as well as not work in a CMH setting. Counselors in private practice settings were found to report higher wellness levels than those in other settings, with CMH counselors reporting the lowest wellness.

Lawson and Myers (2011) and Lawson (2007) also examined the professional quality of life of counselors. As noted previously, the ProQOL contains three subscales including Compassion Satisfaction, Burnout and Secondary Traumatic Stress. Both studies found that CMH counselors scored higher on Burnout than other types of counselors (i.e., private practice, K-12 or university). Counselors in the both studies reported better overall scores on the ProQOL than norming groups; however, within the samples there were some counselors who scored above or below the cutoff scores. For instance, Lawson (2007) found that 14.2% of counselors scored below the cutoff for Compassion Satisfaction whereas Lawson and Myers (2011) found 8.9% of counselors scored below the cutoff. This may indicate that these counselors are having difficulty

finding satisfaction or fulfillment from their jobs as counselors. In addition, between 5.2% (Lawson, 2007) and 6.1% (Lawson & Myers, 2011) reported a Burnout score above the cutoff point. Whereas this could simply indicate that these respondents were having some acute difficulty when reporting, it could also imply that this group of respondents experienced true burnout, which would likely impact their ability to perform work responsibilities. Finally, between 10.3% (Lawson and Myers, 2011) and 10.8% (Lawson, 2007) of respondents reported Compassion Fatigue scores above the cutoff point.

Both Lawson (2007) and Lawson and Myers (2011) examined Career Sustaining Behaviors (CSBs) among counselors. Interestingly, both studies found respondents identified very similar CSBs. These included (a) maintain a sense of humor, (b) spend time with partner/ family, (c) maintain balance between professional and personal lives, (d) maintain self-awareness, (e) maintain a sense of control over work responsibilities and (f) reflect on positive experiences. Further, the least endorsed CSBs were noted as (a) use substances to relax, (b) discuss work frustrations with friends, (c) participate in peer support groups, (d) participate in personal therapy, (e) receive regular clinical supervision, and (f) engage in formal relaxation activities. It is easy to begin to identify various third-order factors of wellness within the list of CSBs that are important in maintaining wellness. For example, humor, awareness of emotions, a sense of control, reflecting, and balance of work and personal life identified as part of the top CSBs. It is clear that components of the Creative Self seem important to counselors in maintaining wellness. A further investigation into the role of the third-order factors of wellness could lead us to a greater understanding of experiences of practicing counselors with regard to

their wellness and impairment. Lawson and Myers (2011) found that overall there was a positive relationship between Total Wellness and Compassion Satisfaction while there was a negative relationship between Burnout and Compassion Fatigue with Total Wellness. Whereas, this is not surprising, future studies could expand upon this perhaps by more specifically examining the CMH setting or experience levels of counselors. The current proposed study would offer entry-level counselors in CMH settings the opportunity to explain in their own words how they incorporate CSBs into their personal and professional lives to increase wellness.

One surprising result regarding CSBs and wellness was that counselors tended to place supervision and support as a lower priority. This is interesting considering that supervision is often suggested as a way to mitigate impairment for counselors (Bellet al., 2003; Newell & MacNeil, 2010; Trippany et al., 2004). Lawson (2007) reported that counselors who received more than the mean of 1.26 hours of group supervision per month scored higher on burnout and compassion fatigue than those who received less group supervision. Similarly, counselors who reported more than the mean of 3.81 hours of individual consultation per month scored higher on compassion fatigue and burnout than those who reported less consultation. These findings bring up concerns regarding supervision and consultation as a means of encouraging wellness among counselors. The author (Lawson, 2007) indicated that one theory of explanation for these findings is that counselors involved in more supervision may simply be more aware of their feelings or experiences of burnout or compassion fatigue. An alternative theory that warrants exploration is consideration of the setting and counselor experiences around professional

autonomy and organizational policies. For instance, in many CMH organizations there is a requirement for multiple team meetings or personnel meetings to cover not only clinical issues but also organizational issues. These would be important questions to ask in future studies. What is clinical supervision and administrative supervision like in CMH settings? How do these factors impact perceived wellness or impairment levels for counselors? The proposed study will ask these very questions of entry-level counselors in CMH by allowing them to indicate in their own voice what their supervision experiences are and how these impact wellness or impairment.

One additional finding related to exploring entry-level counselors in CMH settings is that licensed counselors self-reported a higher satisfaction overall than did counselors who identified as non-licensed (Lawson, 2007). In reporting demographics, Lawson did not specify what license meant. For instance, he reported that 71% of respondents were licensed as a professional counselor or the state equivalent. This does not provide adequate information in order to consider the meaning of the term professional license. Does non-licensed imply that the respondent is seeking a full unrestricted license and is under supervision? It seems this is the case as he only included working professional counselors in the study. However, this is further evidence that entry-level counselors are largely neglected and that inconsistencies in the terminology used both by state licensing boards, authors and researchers creates difficulties in identifying needs for this specific group of counselors as defined for the current study.

Similarly to Lawson (2007), Sprang et al., (2007) conducted a foundational study in which impairment factors were examined for a group of mental health professionals.

The authors utilized a demographic survey and the ProQOL. They indicated that the purpose of their study was to include multiple characteristics of mental health providers (i.e., age, gender, educational level, licensure, years of experience, setting and trauma training) and examine the relationship these factors have with ProQOL variables such as CF, CS, and burnout. One immediate limitation that must be considered in this study is the wide range of professionals that were included in the sample. Sprang et al. included respondents with Bachelor's degrees, Master's degrees, PhDs, and MDs. This clearly creates a significantly heterogeneous sample and with that, difficulty in understanding some of the results. Nonetheless, this study did provide some foundational information when considering organization setting, caseload factors and clinical experience levels. In addition, it should be noted that the sample was limited to a rural state rather than a more representative national sample.

The researchers found that MDs scored higher on impairment scales than respondents with other degrees. In addition, the inpatient setting was found to correlate with responses of higher burnout. This would be expected in that MDs are much more likely to work in an inpatient setting than other degree holders. Whereas the experiences of MDs and other professionals should not be completely overlooked, it does not seem significant to the purposes of understanding the experiences of professional counselors in the CMH setting, taking into account experience level. Given this finding, it seems important in future studies to consider a more homogeneous sample in order to more accurately gauge the relationships of experience, setting and impairment. Indeed, the

current proposed study will include a homogenous sample in order to more fully understand these relationships.

One very significant finding in this study that deserves more attention is that there was a relationship between higher levels of CF and burnout with female gender, younger age, higher education, less clinical experience and higher caseload with clients suffering from PTSD. Whereas other studies have found no wellness or impairment differences for gender or race (Lawson, 2007), some have noted that there seems to be a relationship when multiple factors are included (Lent & Schwartz, 2012). In addition, caseload factors have indicated higher impairment and lower wellness (Lawson & Myers, 2011). This is an important consideration in determining what CMH factors might increase impairment and impede wellness, given that burnout has been attributed more to caseload size and workplace stress rather than client issues (Stamm, 1997).

Lent and Schwartz (2012) conducted a promising study in which work setting, demographic features and personality factors were examined in relation to burnout. Their sample was limited to professional counselors; however, in the report of licensure of respondents it was unclear what the specific titles meant. For instance, 56% of respondents held a state professional counselor credential or licensed professional counselor license. Forty-four percent of respondents held a state professional clinical counselor or licensed clinical professional counselor license. It is likely that these are specific titles for levels of licensure but there is no explanation of limited license vs. full licensure. This is an ongoing difficulty in identifying subgroups by experience when licensure is used to describe the sample. Many states offer a limited or restricted license

while under supervision and completing experience requirements beyond the graduate degree. This may indicate that a significant portion of the sample of this study was under supervision and lacked experience. Indeed, 30% of the respondents indicated that they had 0 – 4 years of experience.

To determine degree of burnout among respondents, Lent and Schwartz (2012) administered the Maslach Burnout Inventory (MBI). To determine personality features respondents completed the International Personality Item Pool Big Five (IPIP). The authors were primarily interested in (a) determining if burnout differed between practice settings, (b) how years of experience, sex or race impacted burnout and (c) if personality characteristics predicted burnout for counselors. Indeed, MANOVA results revealed that work setting did account for 6.2% of the variance reported for burnout. It appears that counselors working in CMH settings scored significantly lower on the subscale of personal accomplishment (Cohen's $D = -.63$), higher on emotional exhaustion (Cohen's $D = .81$) and higher on depersonalization (Cohen's $D = .60$) than did respondents working in private practice settings. In addition, CMH counselors scored higher on emotional exhaustion (Cohen's $D = .54$) than did their counterparts who worked in inpatient settings. This finding is consistent in some ways with the report that Sprang et al. (2007) indicated higher burnout levels within the inpatient setting compared to other outpatient settings, including CMH, but also included MDs in their study. Considering that Lent and Schwartz (2012) only included counselors, one assumption could be made that the presence of MDs in the Sprang et al. study skewed the results regarding inpatient

settings, suggesting that physicians are experiencing more burnout as opposed to the setting.

When Lent and Schwartz (2012) examined demographic variables in relation to burnout no interactions were significant on the two-way analyses. Rather, there was a significant three-way interaction found among burnout and counselor sex and years of experience ($F(9, 9948) = 2.36, p < .05$). The authors considered this finding to be significant in that there is likely a more complex interaction between demographic factors along with environmental factors. They suggested that organizational discrimination, such as racism or sexism, could possibly contribute to this finding. There is not strong support for this finding elsewhere and, therefore, warrants additional attention and examination in order to help determine the organizational or contextual factors experienced by counselors in their early years of CMH work.

A further finding reported by Lent and Schwartz (2012) is with regard to personality traits. The researchers conducted a standard multiple regression analysis and found that the burnout subscales of emotional exhaustion was significantly predicted by neuroticism on the personality measurement ($t = 11.36, p < .001$). Emotional exhaustion seemed to increase as neuroticism increased. Neuroticism is described with generally negative traits such as a lack of emotional stability, impulse control deficits, anger, self-consciousness, vulnerability and increased anxiety (Goldberg, 1999; Lent & Schwartz, 2012). Whereas this study did not include an analysis of the potential relationship between neuroticism, years of experience and setting, it should be considered if entry-level professionals would be more likely to exhibit attributes of neuroticism due to

transitional issues and simple lack of experience. When considering counselor development and supervision, multiple models suggest that counselors with limited professional experience will display anxiety and confusion (Skovholt & Rønnestad, 2003; Stoltenberg, 1983). Future studies should incorporate analysis of the experiences of anxiety among counselors related to both years of experience and work setting. Furthermore, this study contributed a great deal of information regarding levels of burnout and relationships among important factors such as work setting, experience and personality traits but did not examine why these relationships are present. The proposed study will allow entry-level counselors to express experiences of anxiety they may have related to years of experience as well as setting of practice. This will provide empirical data to validate previous findings and models that have suggested that less experienced counselors experience higher levels of anxiety.

Randolph (2010) completed a dissertation study examining the differences in public sector and private sector work settings of counselors. He reviewed responses from a national sample of professional counselors on measurements of both wellness and burnout. Whereas Randolph set out to determine if there was a difference between levels of burnout and wellness among counselors practicing in the two different settings of private sector and public sector (i.e., CMH), limited information was disclosed regarding wellness and burnout scores. Research questions were limited to relationships between factors of burnout and wellness with differences between the settings in which counselors work. Specifically, demographic characteristics such as gender, race or years of experience were not examined.

Randolph (2010) sent out a request for participants through a national counseling association list-serve. A total of 229 usable participant responses were analyzed. The survey consisted of a general demographic questionnaire, the Maslach Burnout Inventory (MBI) and the 5F-Wel. He did note that the levels of the burnout measurement scores were higher for those in the public sector than for those in the private sector. Furthermore, wellness scores were reported as lower for those in the public sector. An overwhelming majority of the respondents were Caucasian (94%) and 77% were female. The sample consisted of mostly self-identified counselors with both Master's degrees (42%) and PhDs. In addition, a small portion of respondents classified themselves as psychologists (6%). Randolph did indicate that there were more PhD level respondents within the private sector when compared with Master's degrees in the public sector.

Randolph found that public sector counselors scored higher on burnout scales such as emotional exhaustion and depersonalization when compared with private sector counselors. In addition, public sector counselors scored lower on the personal accomplishment subscale than their counterparts in private practice. Furthermore, private sector counselors scored higher (84.18) on Total Wellness than public sector counselors (81.75). Although this finding does not indicate a statistically significant difference in Wellness scores, it is helpful information in determining overall wellness and impairment differences between the two groups of practicing professionals, taking setting into account. Randolph's findings were consistent with other studies that have determined differences in wellness and impairment for counselors in the public or community sector (Lawson & Myers, 2011; Lent & Schwartz, 2012; Melamed, Szor, & Bernstein, 2001).

An interesting consideration from this study is that Randolph found that when wellness factors were examined in context of the second-order 5F-Wel factors there were some differences and applicable comparisons. Regarding the Essential Self, public sector counselors did score significantly lower (83.37) than did private sector counselors (96.8). The Essential Self holds the third-order factors of spirituality, gender identity, cultural identity and self-care. Furthermore, public sector counselors scored lower (83.86) on the Creative Self than private sector counselors (86.41). The Creative Self combines the third-order factors of thinking, emotions, control, work and positive humor. This finding is consistent with the results reported by Lawson and Myers (2011) in that the various third-order factors began to emerge within the CSB rankings. When considering these findings against Lent and Schwartz's (2012) report regarding interactions between race, sex and years of experience within the CMH setting, it seems consistent that there are workplace factors to be considered. Minority female counselors may experience racism, sexism and other organizational disturbances that impact wellness and impairment. In addition, CMH organizational variables may impact third-order factors of wellness for counselors.

Randolph (2010) provided some important base knowledge on the topic of counselor wellness and impairment within the context of work setting. He suggested further study is needed in this area to help determine what factors specifically impact counselor wellness and impairment. In addition, Randolph's study did not incorporate demographic differences such as age or level of experience beyond degree type. Whereas this study design has assisted with understanding more of the needs of counselors in the

CMH setting, it did not address the problems or experiences of entry-level counselors in the CMH context. This leaves open the need for a study to specifically explore the CMH setting with counselors of less professional experience.

One recent study provided an opportunity for entry-level counselors to begin to lend a voice to the literature. Freadling and Foss-Kelly (2014) conducted a phenomenological qualitative study in which they questioned six entry-level professional counselors about their experiences in the CMH setting. Whereas this study did not specifically address wellness and impairment, the researchers did begin to acknowledge the existing gap in the literature, which has long neglected the experiences of counselors within the setting of CMH.

The researchers reported that participants identified themes related to the context of CMH, preparation from their graduate training, and various supportive factors. Participants reported that their primary concerns within the CMH setting involved a low wage, lack of funding to meet client service needs, over extended time demands, and excessive documentation. In addition, participants identified that they valued their graduate training but felt that it was inadequate related to specific complex populations and crisis situations. The authors noted the need for future research on a larger scale and to include quantitative studies that could apply to the larger counselor education community.

Further, the participants noted that supportive factors that helped them to effectively manage the stressors they experienced included professional and social supports, boundaries, ability to focus on the client, and future aspirations. Participants

identified supervisor support along with peer support as effective. Keeping boundaries related to time and client issues was important to the participants. In addition, a limit to detractors from client issues was noted as important as well. This involved a type of boundary related to managing documentation demands and remembering that their purpose for entering the field was to help others. Lastly, the participants identified that having a future oriented perspective was helpful to them in managing potentially stressful experiences. The authors identified this as disheartening in that the entry-level counselors only seemed to consider the CMH setting as temporary.

These findings further point to the need to examine the experiences of entry-level counselors within the CMH setting. Specifically, wellness factors and experiences which potentially lead to impairment need to be identified in order to support these counselors and to ensure that clients in need receive valuable care.

Summary of Wellness and Impairment

Myers, Sweeney and Witmer (2000) articulated what has become the basis for the most widely researched model of wellness when they stated that wellness is:

A way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community. Ideally, it is the optimum state of health and well-being that each individual is capable of achieving. (p. 252)

The Indivisible Self model of wellness was developed upon Adlerian principles which accounted for the holistic view of the self (Myers & Sweeney, 2005). The IS-Wel consists of the (a) Creative Self, (b) Coping Self, (c) Social Self, (d) Essential Self, and

(e) Physical Self (Myers & Sweeney, 2005); all parts which make up the first-order factors of the self.

Whereas much research has been conducted using wellness factors, including the IS-Wel model, limited research has examined counselor wellness (Lawson, 2007; Lawson & Myers, 2011; Mobley, 2004). The existent literature regarding counselor wellness has addressed counselor educators (Shillingford et al., 2013; Wester et al., 2009), counseling students (Lambie et al., 2009; Moorehead et al., 2012; Myers et al., 2003; Perepiczka & Balkin, 2010; Roach & Young, 2007; Smith et al., 2007), and professional counselors (Lawson, 2007; Lawson & Myers, 2011; Martin, 2012; Mobley, 2004; Myers et al., 2003; Nesweld-Potter et al., 2013; Randolph, 2010). Unfortunately, researchers have largely neglected examining wellness among counselors entering the field following graduate training. Similar to the wellness literature, very little empirical attention has been given to the issue of counselor impairment among entry-level counselors.

Impairment has become a critical component of counseling ethics. Indeed, even in the current 2014 Code of Ethics, ACA addressed the need for counselors to remain aware of their potential for professional impairment. It has been established that left unaddressed, excessive degrees of counselor stress and inadequate or ineffective coping interventions may develop into impairment (Lawson & Venart, 2005). Four key components were identified in the literature related to impairment. These included (a) burnout, (b) compassion fatigue, (c) secondary traumatic stress and (d) vicarious trauma. Impairment has been somewhat arbitrarily split into personal factors and work related factors (Lawson, 2007; Maslach, 2003; Skovholt and Trotter-Mathison, 2011). Lawson

(2007) implied that personal variables are based on the counselor's subjective perception of wellness or impairment, whereas professional variables include such things as organizational setting, caseload factors and professional support. Burnout seems to encompass these organizational factors. Potential impairment related more to the nature of counseling work are best represented by compassion fatigue (CF), vicarious trauma (VT), and secondary traumatic stress (STS).

From the research presented in the preceding section, it is reasonable to conclude that there is a relationship among wellness, impairment and CMH setting in that counselors working in the CMH setting experience lower wellness and increased impairment (Lawson & Myers, 2011; Lent & Schwartz, 2012; Randolph, 2010). In addition, it appears that there are other relationships with wellness and impairment among demographic variables such as years of experience, gender, and race yet to be discovered (Lent & Schwartz, 2012; Sprang et al., 2007). The research presented leaves some gaps that need to be explored. In order to understand the experiences of entry-level counselors in CMH settings it will be useful to utilize a qualitative design that will allow for the voice of the counselor to be heard. The current study allowed entry-level counselors to express their own experiences related to wellness and impairment and clarify potential relationships (which may or may not exist) between these variables and years of experience and setting. Further, inquiry regarding what factors CMH counselors report as contributing to impairment or wellness provided a clearer direction for future research specifically addressing the CMH setting.

Chapter Summary

This chapter has identified the population of interest in this study as entry-level professional counselors practicing within the context of CMH settings. A review of the literature pertaining to this population and setting was included. Further, the concepts of wellness and impairment were described and explained. Research specifically addressing wellness or impairment of entry-level counselors within CMH settings was presented. It was established that multiple gaps exist in the literature regarding this group of counselors. First, research of counselors beyond graduate training is sparse. The experiences of this group of counselors remain unknown. Relatedly, consideration of licensure requirements of entry-level professional counselors was explored in the context of supervision and development. Researchers have found that experience level and setting of practice impact wellness and impairment scores. It is unclear what mechanisms account for these relationships. Furthermore, the CMH setting has been related to increased impairment and lower wellness yet there is limited research exploring this general finding. The current study is proposed to begin to give a voice and explanation of the relationships among level of experience, CMH setting, wellness and impairment. Further, this study began to address support and prevention of impairment for this group of counselors. The details of the current study are addressed in Chapter III.

CHAPTER III

METHODOLOGY

Overview

The purpose of this chapter is to describe and explain the research methods used in this study. Research questions are restated in this chapter. The associated procedures of Consensual Qualitative Research (CQR) are explained. Limitations of the study are discussed. The chapter concludes with a report of the process of the pilot study and revisions. Modifications made to the full study as a result of the pilot study are reported at the conclusion of the chapter.

Research Questions

The research questions for this study were introduced in Chapter 1 and are restated below. Research questions in CQR are intended to be exploratory and open for participants to describe their experiences regarding the topic of study (Hill, Thompson, & Nutt Williams, 1997). The research questions for this study have been developed with the desire to emphasize description of experiences of participants rather than explanation (Hill et al., 1997). Therefore, the research questions do not contain hypotheses regarding the directionality of results (Crook-Lyon, Goates-Jones & Hill, 2012; Hill et al., 1997).

1. What are the overall experiences of newer professional counselors working within community mental health settings and their impacts to professional quality of life and wellness?
2. How do entry-level professional counselors working in community mental health settings perceive the impact of organizational factors on their professional quality of life and wellness?
3. How do entry-level professional counselors working in community mental health settings perceive the impact of client factors on their professional quality of life and wellness?
4. How do entry-level professional counselors working in community mental health settings perceive the impact of personal factors on their professional quality of life and wellness?
5. How do entry-level professional counselors experience developmental critical incidents within the setting of CMH?

Participants

Qualitative researchers seek out participants who will fit best with the research questions in order to obtain the most appropriate information (Hill & Williams, 2012). Participants in qualitative studies must be selected according to specific criteria rather than randomly representative of a population (Hill & Williams, 2012; Polkinghorne, 2005). Qualitative researchers generally do not seek to gain universal knowledge in the same way that quantitative researchers do (Wang, 2008). Rather, qualitative investigations are designed to explore specific experiences of participants (Ponterotto,

2005; Wang, 2008). Whereas the specific experiences of participants are most important in qualitative research, if the sample for a qualitative study has been carefully chosen the information gleaned from the participants may be transferrable to a larger population when researchers identify themes reported across participants (Hill, et al., 2005; Stahl, Taylor & Hill, 2012). CQR researchers prefer to use the term “transferability” rather than “generalizability” as this allows readers to determine if the results are applicable to a greater population than the sample (Williams & Hill, 2012).

Because the researcher sought to understand and explore the experiences of entry-level counselors specifically in the context of community mental health settings, it was necessary to screen participants to ensure that they possessed the qualities or characteristics being examined. This purposive selection of a sample meant that the number of participants was relatively small (Polkinghorne, 2005). In addition, to encourage the transferability of results to the larger population of entry-level counselors beyond this study, the researcher attempted to gain a relatively homogenous sample.

Participants included 11 entry-level counselors who had graduated with a Master’s degree in Counseling from a North Carolina, Counseling for Accreditation of Counseling and Related Educational Program (CACREP) accredited program. Further, participants held a restricted or limited license in the state of North Carolina. Restricted or limited licensure means all educational requirements have been met; yet supervision requirements by a qualified supervisor are still needed to obtain independent licensure. Counselors selected for the study possessed no less than 1,000 hours of post-graduate experience and no more than 2,000 hours of post-graduate experience. Participants were

all currently employed full-time at a community mental health organization. Participants also identified that at least 50% of their time was spent in direct client care. Consistent with professional license laws in North Carolina the participants were required to be receiving supervision toward a full license (GS 90-336; 21 NCAC 53).

Procedures

Potential participants were recruited through several avenues. The student researcher accessed existing contacts to locate participants within the community mental health setting. Further, the researcher expressed interest to current supervisees who informed peers of the study but did not include those supervisees in the research. This particular technique of recruiting potential participants is referred to as a snowballing strategy (Patton, 1990; Polkinghorne, 2005). Snowballing generates interest in the study by utilizing individuals who may already have an interest in or experience with the topic of study.

Recruitment using these initial contacts proved to be limited and necessitated a different approach to locate participants. The primary researcher contacted the state licensing board to obtain a list of licensees that held the specific credential needed for the study. Once the list was reviewed for accuracy, a recruitment email (Appendix F) was sent out that included avenues to contact the primary researcher as well as a web-based screening tool that allowed participants to review the study protocol while maintaining anonymity (Appendix D). The web site then gave the participant the option to leave their information and express interest or to contact the researcher directly. Further, the primary researcher attended a state conference and recruited potential participants during poster

presentations and vendor allotted time periods. This included the distribution of the research study protocol. The primary researcher utilized social media to a minimal extent by posting the link to the web site for interested participants on a counseling association social media site as well as on a counselor education program's social media site. In addition, a state counseling association included the recruitment statement and link to the web site in their monthly newsletter to members.

The lead researcher initiated a recruitment email (Appendix F.) to potential individuals who expressed an interest in the study. When potential participants responded to recruitment emails, the researcher followed up via email or phone call with more detailed information and identified the appropriateness of the participant. Potential participants were given an informational statement that included the topic and purpose of the study, the general time commitment, potential risks and benefits of participating, and confidentiality measures (Appendix E).

Participants selected and who had agreed to participate received a full informed consent document (see Appendix B) as approved by the university Institutional Review Board (IRB). The informed consent articulated clearly the goals of the research, the process that participants could expect, as well as the expectations of the participants. Information about participants' ability to decline at any point in the study was included. Potential participants were notified that during the interview process they would be audio or video recorded for the purpose of data collection and review. Potential participants were notified of how their personal information would be stored and used in the process of research. In an effort to maintain participant anonymity, demographic information was

only available to the student researcher and was removed during data review and analysis.

Because qualitative research intentionally utilizes open questioning and interviews, there is potential for participants to experience personal emotional responses to questions (Burkard, Knox & Hill, 2012). Whereas this can add to the richness of the results (Polkinghorne, 2005) it was important to manage participant response and protect them from harmful reactions (Clark & Sharf, 2007; Haverkamp, 2005; Heppner, Wampold & Kivlighan, 2008). One advantage to conducting qualitative research is the relational dynamic between researcher and participant (Haverkamp, 2005). This relational element allows for a continued disclosure and consent within the research process. Participants are continually able to reflect and process their responses to researcher probes which in turn allows them to actively decide at what emotional level they participate in the study (Burkard Knox, S., & Hill, C. E., 2012; Haverkamp, 2005). In preparation for the unlikely event that a participant disclosed or exhibited a negative reaction causing emotional distress, resources were identified for the participant to process the distress further through a debriefing, supervision or counseling session as needed. No participant disclosed any negative reaction to the study during the process.

Due to the relatively small nature of the sample, an incentive to participate was provided in the form of a \$15 gift card to an online bookstore for every participant. This may have served as incentive for the entry-level counselor participants especially as they may be actively building their professional library. However, there seems to be no

incentive for these busy professionals that can make up for the time they spent participating (Hill & Williams, 2012).

Demographic Questionnaire

The demographic questionnaire was a brief assessment of the participant's experience level and related characteristics. The questionnaire consisted of 18 questions including age, gender identity, racial identity and relationship status. In addition it asked participants about their education level, professional license information and current work environment. Given the topic of study was focused toward clinical mental health (CMH) environments participants were asked more detail regarding the CMH organization at which they are currently employed. Additional information such as amount of time spent on varying case types and supervision was obtained in the demographic questionnaire. The full demographic questionnaire is available in Appendix G.

ProQOL

The Professional Quality of Life measurement (ProQOL; Stamm, 2009, 2012) was utilized with participants in addition to the interviews. The ProQOL is a no-cost brief questionnaire developed to identify (a) Compassion Satisfaction, (b) Compassion Fatigue, (c) Burnout, and (d) Secondary Traumatic Stress (Stamm, 2010). It consists of 30 statements directed at helpers or counselors. The statements may be modified to address the appropriate population group. For instance, the original language used in the statements is *helper* but may be changed to counselor, therapist or other term as needed. For this study the term counselor was consistently used. Respondents were asked to

identify how often they have felt the statement is true of themselves within the last 30 days. The ProQOL is currently in its fifth version. The ProQOL has good construct validity based in the literature and has been cited over 200 publications using the scale. The ProQOL measures the constructs of Compassion Satisfaction, Burnout and STS. Internal consistency of the ProQOL has been noted as good with alpha reliabilities as follows (Stamm, 2010): Compassion Satisfaction (.88), Burnout (.75), and Secondary Traumatic Stress (.81). (Stamm, 2010).

The current study was designed to explore the experiences of entry-level counselors related to these concepts. The ProQOL was included with the demographic form and the interview questions and did not require any analysis of the data obtained. Participants completed the ProQOL items using Qualtrics software. Participants were able to see their personal results immediately. They were given the directions and a web link to more information regarding the findings of their results if desired. A copy of the ProQOL can be found in Appendix H.

Whereas the ProQOL was not intended as a screening tool for participation in the study, its use further assisted in ensuring that an appropriate and more homogenous sample was used. This measurement also assisted in describing the sample in a more detailed manner. Further, the use of the ProQOL helped the research team to contextualize the qualitative data alongside the results of the ProQOL. Use of the ProQOL provided the research team with a different perspective from the participants that helped to triangulate the data and thus became a source of external validation of the interview results (Hill et al., 1997).

Interviews

Qualitative inquiry is one that provides researchers with the ability to seek out deeper meaning and facilitate understanding of experiences that are not otherwise defined (Polkinghorne, 2005). With this expectation of uncovering experiences of participants, qualitative research methods require examination of language, beliefs and process (Burkard et al., 2012; Hill et al., 1997; Polkinghorne, 2005). Qualitative research necessitates the use of interviews and open questioning (Burkard et al., 2012; Polkinghorne, 2005). Particularly in CQR, the semi-structured interview is the tool by which the researcher gains access to valuable data (Burkard et al., 2012; Hays & Wood, 2011; Hill et al., 1997). Significant time was spent on developing the interview protocol in order to ensure that information for this study was obtained at the most productive level (Burkard et al., 2012; Hill et al., 1997).

The interview questions were based on the previously presented research questions. A review of the literature regarding entry-level counselors, wellness, community mental health settings (specifically typical clientele and organizational factors), and supervision was conducted to establish the proper research foundation and areas of need for research as well as to inform the interview question (Burkard et al., 2012). The student researcher also reflected upon personal experiences as a community mental health counselor and supervisor in the context of the community mental health setting. The student researcher began the process of generating the interview questions, corresponding to each research question. (A grid showing the correspondence of interview questions with each research question can be found in Appendix L.) Interview

questions were intended to be presented in a semi-structured format to ensure that research questions were answered to the fullest extent possible during interviews. This was in accordance with CQR protocol. Whereas some other forms of qualitative investigation (i.e. phenomenological) utilize open-ended questions to examine broader lived experiences of participants, CQR interviews are intended to provide direction based on literature and research questions posed.

These questions were provided to two dissertation committee members who reviewed them and provided suggestions and feedback. The student researcher and research team members discussed a “working” version of the questions. As part of the pilot study (explained below), and as encouraged by authors of CQR literature (Burkard et al., 2012; Hill et al., 2005; Morrow, 2005), the interview questions were also reviewed multiple times by research team members, an expert peer from within the community mental health field, and two current entry-level professional counselors. Modifications were made based on feedback received from these reviewers. The final interview protocol was developed and refined based on dissertation committee, faculty review, research team, pilot participant feedback, and dissertation proposal review by additional faculty members (Appendix I).

The developers of CQR have suggested that the researcher utilize interviewers that possess skills needed to conduct quality interviews (Burkard et al., 2012; Hill et al., 2005; Hill et al., 1997). Generally, these qualities fit with those of a counselor (e.g., ability to be empathic, to reflect feeling, to use open-ended questions and restatement). Interviewers must have the ability to manage time and be intentional while gathering

information (Burkard et al., 2012; Hill et al., 1997; Yin, 2009). Furthermore, investigators in qualitative research have an interest in developing a relationship with participants in order to co-construct meaning during the research process (Haverkamp, 2005). This collaboration unique to qualitative research allows for the researcher(s) to conduct the interviews with participants (Morrow, 2007). It has been suggested that researchers may use more than one interviewer (Burkard et al., 2012; Hill et al., 1997); however, for this research study only the student researcher conducted the interviews for the purpose of ensuring consistency across research interviews (Hill et al., 1997).

Considering the multifaceted topic of investigation for this study, participants were given the interview questions in advance of the interviews, a procedure strongly recommended by Burkard et al. (2012). This enabled the participants to consider their experiences in advance and possibly at a more developed and succinct level that could facilitate deeper conversation during the actual interviews. Furthermore, Burkard et al. (2012) proposed that giving interviewees the information beforehand allows them to actively decide their level of participation and meets ongoing needs for informed consent.

It is important to note that the student researcher is a clinician and clinical supervisor and is accustomed to conducting clinical interviews in an effort to obtain diagnostic criteria or other clinical needs. A research interview has a very specific goal of understanding the participant's perspective regarding the research topic (Polkinghorne, 2005). The skills of a clinician, such as gaining rapport and the ability to ask good questions, were certainly helpful while conducting interviews (Wang, 2008).

Considering that CQR is a relational form of inquiry, the interviews began with relatively simple and personally-engaging questions with limited research intent in an effort to develop researcher-participant rapport (Burkard et al., 2012). To meet this need, the first semi-structured interview question was related to the participant's job title or role. Following the introduction to the interview, a semi-structured interview protocol was followed. Due to geographical limitations and scheduling availability, all but one of the participants were interviewed via Skype. (One of the participants was able to meet in person.) All interviews were audio recorded using a digital recording device. No video recording occurred. Interview times ranged from 40 minutes to 1 hour and 20 minutes. There were a total of ten interview questions. The interview questions are listed below. For a detailed explanation of the relation of interview questions to the research questions see Appendix K. Raw data from participant interviews is available in Appendix M.

1. To get started, I want to learn a little about your experiences of being an entry-level counselor in a community mental health agency. Tell me about your job and role as a counselor in a CMH setting.
2. Researchers have found that experience level of counselors and the setting of CMH sometimes impacts counselors' experiences of things related to professional quality of life. I would like to talk about the Professional Quality of Life scale that you completed. Please describe what your experience was like taking this survey. What thoughts or feelings about your own experiences as an entry-level counselor working in CMH did it bring up for you?
3. Tell me about why you chose to work in a CMH agency?

4. In CMH organizations there are usually additional job responsibilities or duties along with client care such as paperwork, documentation, technology, insurance, Medicaid, compliance, etc. What has your experience of these types of things been since starting in the CMH setting? *Probe:* How do you see these impacting your ability to work as a counselor?
5. Describe the types of clients and client issues that you work with in the CMH setting?
6. How do you think that the issues your clients face regularly, impacts you both professionally and personally?
7. What prepared you to deal with your work as a counselor?
8. How do you deal with stress or self-care?
9. It has been considered that counselor development is facilitated by supervision. In addition, it is a requirement for entry-level professional counselors. Describe your supervision.
10. Discuss any positive and negative components of supervision for you in the setting of CMH?

Consensual Qualitative Research

The developers of CQR sought a form of qualitative inquiry in which themes from data are allowed to emerge while maintaining standards for rigor within the scientific method (Hill et al., 1997). CQR provided a systematic process that adhered to standards and used multiple researchers (i.e., the research team, multiple reviews compiled data, audits) to meet consensus regarding data (Hays & Wood, 2011; Hill et al.,

1997; Hill et al., 2005; Williams & Hill, 2012). The ability to come to consensus with a research team honored the philosophical differences present when interpreting data and allowed for a richer interpretation of results (Hill, 2012). Stahl et al. (2012) identified four major steps in the CQR process: (a) using semi-structured interviews with open-ended questioning, (b) the use of domains to sort data into broad categories, (c) summarizing data into core ideas from each domain, and (d) the use of cross-analysis to determine patterns from the data.

Throughout the entire process of CQR an auditor served to question the appropriateness of placement of data within categories, core ideas and patterns (Hill et al., 2005; Schlosser, Dewey & Hill, 2012). Whereas the research team was made up of internal members with some expertise and interest in the topic of study, the auditor generally served as an outside member with methodological expertise who offered feedback and critiques of the process (Hill et al., 2005; Schlosser et al., 2012). This section includes a detailed description of the process used in the study following protocol of CQR.

Data analysis began with coding the raw data into two parts: (a) domains and (b) core ideas (Thompson, Vivino & Hill, 2012). Coding qualitative data in CQR provides a conceptual framework for researchers to manage what may be a large amount of data (Hill et al., 1997; Thompson et al., 2012). The beginning stage of analysis included developing domains (Thompson et al., 2012). Domains have also been identified as topic areas (Hill et al., 1997). Researchers have the option of using a list of topics that is based in the literature and the research questions (Miles & Huberman, 1994; Thompson et al.,

2012) or developing a list of topics that emerge from the raw data collected in the interviews (Thompson et al., 2012).

The next phase of the analysis process involved summarizing the participants' narratives or constructing core ideas (Hill et al., 1997; Thompson et al., 2012). Core ideas were constructed to further clarify the raw data of the participant narratives into more usable language that aided in the ability to further analyze the data (Thompson et al., 2012). Essentially, developing core ideas in CQR moves the raw data within each domain into a more usable format with fewer words and more concise summaries of the domains (Hill et al., 2007; Thompson et al., 2012). Whereas the development of domains began with a set start list, the development of core ideas began with the research team meeting to review one or two of the verbatim participant responses within each domain. This review helped the research team remain as close to the meaning of the original participant narrative as possible in beginning the process of developing core ideas. Because verbatim response review is time-consuming, the research team only needed to conduct a detailed review of a few select responses to establish confidence and direction in the process (Thompson et al., 2012).

The team auditor then again reviewed the consensus version of the domains and core ideas to provide an objective check of the team's work for consistency and clarity (Schlosser et al., 2012). If the auditor requested any modifications the team made adjustments and came to consensus before submitting to the auditor once again. Once the consensus version had been completed the final stage of the analysis began.

Left with a great deal of data separated into domains and core ideas, the research team began the crucial process of cross-analysis (Ladany, Thompson & Hill, 2012). The purpose of cross-analysis was to identify commonalities across cases and determine more consistent categories in which the data would ultimately lead to a greater understanding of how the data are connected. The task of cross-analysis began by analyzing cases against each other and identifying common themes or categories into which nearly all of the data fit (Hill et al., 1997; Ladany et al., 2012). Categories were established by reviewing one domain at a time and examining the core ideas within each domain. This included using descriptive words to identify how the large amount of raw data emerged into more detailed categories. Ladany et al. (2012) suggested that the research team begin with a small domain in order to get a clear sense of the cross-analysis process. This process has been described as creative and abstract, which requires researchers to be fully aware and knowledgeable of the data (Hill et al., 1997; Ladany et al., 2012). Cross-analysis may necessitate going back to previous steps in the process such as revisiting the core ideas (Hill et al., 1997). As in previous steps, the cross-analysis is submitted to the auditor for review. Ladany et al. (2012) noted that the auditor review and team consensus process might occur multiple times to reach the best possible cross-analysis.

Once categories were established from the cross-analysis of interview transcripts, a frequency of occurrence was determined within each domain. This process provided the ability to determine in a particular manner when information was considered general, typical or variant, (Ladany et al., 2012). For this study, a label of *general* was used when the category was marked in 10-11 cases. The label of *typical* was assigned for categories

marked in 5-9 cases, and *variant* was assigned for categories marked in 2-4 cases. *Rare* categories, or only represented by one case, were not included in the results of this study. It is the frequency labeling that allows researchers to begin to make claims about the sample and have a common metric to discuss results (Hill et al., 2005; Ladany et al., 2012).

The Research Team

Members of a CQR research team typically are selected from those who are able to offer support, time commitment, and who have an interest in the research ideas presented (Vivino et al., 2012). Whereas research teams can involve different configurations to allow for rotation of members or multiple committees, the most common type of research team is a set team (Vivino et al., 2012; Hill et al., 2005). For the purpose of the current study the research team consisted of a set team that followed the process from the beginning to the end. As the current study was part of a doctoral dissertation, one member of the research team also served as dissertation committee member for the student researcher. With exception of the student researcher, all research team members have earned doctoral degrees in counseling and counselor education as well as licensure as clinicians in the counseling field. Research team members were asked to participate in the study during face-to-face meetings or via email.

Student researcher. The student researcher is a 37-year-old Caucasian female. She is a doctoral student enrolled in a counseling and counselor education doctoral program. She also holds a state license to practice as a counselor as well as state approval to provide supervision to counselors seeking licensure. In addition to enrollment in a

prominent doctoral counseling program in the Southeastern United States, she practices as a counselor and supervisor in a local private practice. She teaches undergraduate human services courses in an online format through a local community college. She had no formal CQR experience prior to this study. The student researcher has read extensively on the topic of CQR and relied on direction and guidance of dissertation committee members and members of the research team with more extensive experience. In addition to independent reading she has completed multiple course requirements of various research philosophies in both qualitative and quantitative methods at the master's and doctoral level. She also has experience with informal qualitative program evaluation within the community mental health setting.

Team member 2. A second member of the research team is a Caucasian male with publications on the topics of counselor wellness and supervision. He has a PhD in Counseling and Counselor Education. He has experience with CQR and other research methods. He currently directs the graduate program's counseling clinic and provides supervision to student and professional counselors. He serves as a dissertation committee member for the student researcher.

Team member 3. The third team member is an African-American female who primarily works in a university counseling center. She holds a PhD in Counseling and Counselor Education and has experience in various settings including community mental health and substance abuse. She has no formal experience with CQR but has expressed significant interest in learning the process. She has experience with quantitative research studies.

Auditor. The primary team auditor is a Caucasian female who is a faculty member in a counselor education program and had previously worked with the student researcher in private practice. She holds a PhD in Counseling and Counselor Education. She has significant experience in the CMH setting. She conducted studies using CQR as well as quantitative and mixed methodology. In addition, she has multiple publications and serves as a reviewer for a national counseling journal.

Research team preparation and expectations. In an effort to begin the CQR process in an effective and open manner, the research team met to establish the common goals of the study and to prepare for the pilot study. The agenda for the initial meeting may be found in Appendix J. To begin, the team reviewed the roles of each member as well as basic expectations of the CQR process. In this meeting trust and power differentials were discussed. It was recognized that all members of the research team have completed doctoral degrees with the exception of the student researcher. This placed an obvious power dynamic in the context of the team. Hill et al. (2005) and Vivino et al. (2012) noted the value of the CQR team acknowledging power differences within the team, which opens up dialogue about support and expectations for the process. This awareness was important to the current team, as there exists differences in experience levels with CQR methodology and understanding of the research topic. Furthermore, an environment of support and learning was established. Research questions were reviewed by the team and the purpose of the study was discussed. A preliminary schedule was shared and agreement regarding best forms of communication was determined as email and use of online collaborative sites.

Training is recommended for CQR teams (Vivino et al., 2012); however, since multiple members of the research team have experience with CQR there was no outside formal training required of those without CQR experience. Rather, each member of the team read the seminal publications by the developers of CQR (i.e., Hill et al., 1997; Hill et al., 2005; Hill et al., 2012). During the initial team meeting members reviewed the CQR process. The two members of the research team with prior experience agreed to serve as embedded trainers and answered clarifying questions of the team members. During the initial team meeting the auditor sent via email a published study utilizing CQR for team members to reference (Knox et al., 2003). All team members had consistent access to published resources as well as consultation from more experienced researchers for direction and clarification of CQR procedures.

It is important to note that whereas all members of the team participated in the CQR process and were a valued part of the analysis of data, not all members collected data. This primary role was the task of the student researcher. The initial team meeting included consensus regarding what roles each member would hold and the expectations of how discussion, opinions, and conflicts during the process would be addressed (Vivino et al., 2012). During this initial meeting a bracketing exercise was completed in which team members discussed their ideas and experiences regarding the topic of study. This exercise is detailed below in the following section.

Managing bias and expectations. The ability to acknowledge a researcher's personal experiences is integral in scientific inquiry and is one distinguishing draw to qualitative methods (Denzin & Lincoln, 2000; Haverkamp, 2005; Morrow, 2005).

Maintaining a commitment to ethics in qualitative research requires a specific understanding and process on the part of the researcher as to how his or her own biases impact interpretation to data (Haverkamp, 2005; Sim, Huang & Hill, 2012). A preliminary exploration of the related literature on the topic of study also may have an impact on expectations of the outcome of the research (Burkard, Knox & Hill, 2012; Hill et al., 1997; Morrow, 2005; Sim et al., 2012). It was known that most members of the research team had personal experiences related to being an entry-level counselor and the clientele, organizational factors, and supervision experiences as part of their early clinical work in mental health agencies. In particular, an extensive bracketing exercise was conducted prior to the pilot study and review of the protocol in order to begin the process of managing expectations.

Bracketing has become a phenomenological research concept that is well accepted in many other forms of qualitative research along with CQR (Morrow, 2005; Wertz, 2005). Bracketing involves researcher self-awareness of assumptions about research questions, participants, data or concepts that may interfere or influence the results of a study (Morrow, 2005; Wertz, 2005).

Bracketing process. During the initial meeting with the research team the concept of bracketing was discussed. Team members understood that they were expected to acknowledge their own experiences with the topic of study as well as any expectations they may hold regarding the study (Sim et al., 2012). An environment of respect and trust was emphasized during initial and subsequent meetings in an effort to foster a supportive

atmosphere in which members shared their biases throughout the entire research process (Sim et al., 2012).

All members of the research team participated in the bracketing exercise conducted at the first full research team meeting, prior to completion of the pilot study. Prior to the meeting all team members were sent via email a list of questions to consider regarding the topic of study and possible expectations of the study. (A list of questions and the responses to the questions may be found in Appendix K). The research team identified their individual experiences with the population of study. All research team members acknowledged that at one time they were considered entry-level counselors and therefore identified with the study population in this respect. In addition, all research team members had some experience supervising counselors-in-training and are trained in fundamental theory and technique of clinical supervision. All research team members reported experience working in some capacity in a CMH organization. Two of the research team members noted the belief that it is the responsibility of the individual counselor to manage his or her wellness. All research team members expressed an interest in learning more about the topic of study as well as developing CQR experiences.

There were several implications drawn from the bracketing exercise. First, it was determined that part of the potential bias in this study is the expectation that entry-level counselors in CMH settings primarily have negative experiences. Many of the bracketing responses trended toward negative personal experiences with supervision and organizational factors. This bias had potential to create assumptions that that entry-level

counselors mainly have negative experiences. It was agreed upon that during the review of data, the team should be mindful of hearing positive experiences of participants.

Coding the Data

Data analysis began with coding the raw data into two parts: (a) domains and (b) core ideas (Thompson, Vivino & Hill, 2012). Coding qualitative data provides a conceptual framework for researchers to manage what may be a large amount of data (Hill et al., 1997; Thompson et al, 2012). To simplify collaboration, a shared spreadsheet was created. This allowed access to the data and coding by each member of the team. Collaborative meetings totaled eight in all. Many of these meeting were facilitated via online video chat programs. Much communication occurred between meetings via email.

In preparation for the analysis portion of the research process all interviews were transcribed and included verbatim accounts of the entire interview of each participant. (Burkard et al., 2012). Identifying information was removed from the typed transcriptions to maintain participant anonymity. The members of the research team did not have access to identifying information of participants at any time. Rather, the student researcher assigned a numerical identifier to each participant and that was used in the data analysis (Hill et al., 1997).

This research team operated from a start list based in the existing literature and remained open to modifying the list based on emergent domains within the data. The start list was based in the literature that best described entry-level counselors, counselor wellness, and community mental health. The start list domains included, (a) career

choice, (b) organizational factors, (c) client factors, (d) self-care/ wellness, and (e) supervision.

Even though an agreed upon start list of topics was used, the research team independently reviewed two initial transcripts and then met together to come to a consensus of what were considered appropriate domains. Once data review began another domain developed related to job preparation. Job title or role and ProQOL experience were added to the final domain list for ease of analysis. This resulted in a total of eight domains. Following the first meeting each team member reviewed a third transcript in an effort to further test the domain list. During the second meeting the third transcript was reviewed for consistency among the team. The list of agreed upon domains were then submitted to the auditor for review. The auditor reviewed the team's list to ensure that the team did not overlook important information from the data (Hill et al., 1997).

Once the auditor approved the domain list the research team read the remaining transcripts of the interviews. Transcripts were divided between team members in order to facilitate both time efficiency as well as consistency of coding. The primary researcher reviewed all 11 transcripts whereas the remaining 8 transcripts were split between the two other members. Members of the research team began to assign blocks of raw data to the various domains (Thompson et al., 2012). The research team met multiple times to review the data and the assignment of domains. During the remaining meetings the team reviewed the domains and data placement thoroughly until consensus was reached. When there was a difference in coding between the primary researcher and the team member who reviewed the transcript the third team member served as the deciding factor. This

process was repeated until all members of the research team were satisfied with the consensus and all participant data had been placed into both a domain and summarized into core ideas. Two meetings were facilitated to review the first three transcripts for accuracy and to determine any changes that may have evolved since the original consensus process. No major changes were found.

Following this meeting the auditor was given the final consensus data and all participant transcripts to review. The auditor provided minor suggestions for the team to review. These considerations included the possibility of including two additional categories. These were discussed at a final meeting of the research team. It was determined that the auditor's suggestion related to the opposites of two of the current categories and did not warrant new categories rather, they should be addressed in the results discussion. Once the final consensus was completed, the student researcher evaluated all cases and assigned a frequency label to each category. This final analysis was sent to the research team for any additional and final feedback.

Limitations

Whereas rigor was attempted in the data collection and analysis of this study, all researchers face limitations when conducting studies. One limitation regarding the methodology is that of potential researcher bias. The principal researcher has had significant experiences with the context of CMH settings and supervision of entry-level counselors. CQR was chosen as the preferred method in an attempt to manage bias and create the need for consensus in determining the process of data collection and in interpreting the results. Multiple strategies to reduce bias were administered. This

included the process of bracketing prior to data collection. The CQR team consisted of a diverse group of individuals who provided significant questioning and examination of the research process. Further, the auditing process allowed for questioning of the research team and helped to limit groupthink.

In addition, self-report was used as the primary means of data collection. It is possible that self-report and the ability to prepare for the interviews may have led to biased reactions or that social desirability impacted the participants' responses. The use of the ProQOL was an added attempt to triangulate the data and to provide for richer data collection across participant experiences. Although this was meant to strengthen findings, the design of the study did not indicate further analysis of the ProQOL results.

Finally, one limitation related to the use of CQR is that the results are not generalizable to all entry-level counselors among various states and settings. The targeted and purposive sample in this study contributed to a greater understanding of the experiences of entry-level counselors. However, due to the varied and unique responses from each participant, it is clear that entry-level counselors' experiences are personal. In addition, the participants in this study were largely homogenous in gender and race and did not expand on detailed differences in training. The researchers relied on the assumption that CACREP standards and limiting to the State of NC would support homogeneity among participants. In addition, the semi-structured interview process may have limited participants to share specific experiences and may have limited the information gained from participants.

Pilot Study

Due to the intricacies of developing research studies, piloting and revising the interview protocol was a crucial step in ensuring integrity of CQR (Burkard et al., 2013). Feedback prior to conducting the larger main study provided an opportunity to revise the protocol in a manner in which the questions used could generate the best possible data. The primary purpose of the pilot study was to determine the effectiveness of the interview questions and the interview process.

In addition to the participants' feedback about the questions, information was taken regarding interview location, length of time and other potential needs during the data gathering process. Furthermore, it should be noted that the university IRB determined that the pilot study was exempt from review. The official statement from the IRB is found in Appendix A.

Participants

The pilot study consisted of three interviews. To begin, an expert in the field of CMH reviewed the interview protocol to determine the appropriateness of the interview question. During the second part of the pilot study, the questions were then used in an interview with two participants that met all requirements of the preferred sample.

Expert peer. The student researcher contacted an expert peer with many years of experience in the CMH setting. The expert peer currently works as a supervisor of counselors and social workers in a CMH agency. She has extensive experience with CMH clientele as well as working with entry-level counselors. She was contacted via phone call and given information regarding the purpose of the study. The procedures and

time commitment required was also explained to the peer expert. She agreed to participate in the pilot study by reviewing the interview questions and offering feedback. The initial interview questions (found in Appendix J) were submitted to the expert peer for review via email prior to a face-to-face meeting with the student researcher at the peer expert's office. During the meeting with the peer expert the questions were reviewed individually with notes taken by the student researcher and a copy of the peer's written notes was obtained for further consideration. The expert peer recommended no revisions.

Participant 1. The participant was a 35-year-old Caucasian male who works as a counselor in a CMH agency. The student researcher had interacted with the participant in the past during the participant's internship experience at a local CMH organization. The participant was contacted via email initially to discuss possible interest and availability. Once the participant expressed interest in participating the lead researcher called the potential participant and described the purpose of the study and time commitment. During the phone call the participant agreed to participate and arrangements were made to follow up with an email containing the study protocol and a time to meet the student researcher for the interview. The participant was sent a link to the Qualtrics website containing the informed consent, demographic questionnaire and ProQOL. The participant was given the interview questions prior to the interview as was planned for the main study in order to evaluate the time and clarity of this protocol. The participant agreed to provide feedback regarding the interview process along with answering the interview questions. The interview was conducted in the participant's home using an audio recording device. The location of the interview was the choice of the participant.

Participant 2. The participant was a 55-year-old Caucasian female who works for a CMH agency and has experienced multiple CMH organizations through internships as well as networking through her current position. The participant was recruited for the pilot study through a colleague. The participant was emailed preliminary information and then a follow up phone call occurred. Once the participant agreed via phone conversation to participate, she was emailed a link for the Qualtrics website containing the informed consent, demographic questionnaire and ProQOL measurement. The participant was given the interview protocol prior to the interview. The interview was conducted in the researcher's office as it was determined to be a neutral place for the participant. An audio recording was made during the interview.

Modifications

The final revision to the pilot study interview protocol involved multiple steps. Revisions were based on feedback and recommendations of the pilot study participants as well as from faculty during the dissertation proposal seminar. In addition, revisions were made to the interview protocol based on the experience of the student researcher. The interview questions were found to be generally effective.

There were a few minor revisions made to the questions based on interviewee feedback related to clarification of the questions. Revisions also included lowering the number of interview questions from 14 to 10 to account for time limitations and keeping the attention of the participants. Further, revisions to the questions included the addition of allowance for probing during interviews where redirections may have been necessary. This was to ensure that the participants were answering the questions with content

specific information rather than only contextual story telling. Although questions remain open-ended, simple revisions regarding the context and purpose of the question were made based on review of feedback and transcripts. It was determined that the open-ended format did indeed encourage participation from participants. One limitation to having open-ended questions that was discovered was the need for the interviewer to manage the participant's story telling and recall of specific experiences rather than expression of content that relates to the larger questions.

In addition, it was suggested that because interviewees will receive the interview protocol in advance of the interviews, a statement should be provided regarding the intent of the questions leading to lived experience and meaning behind the stories that participants tell. One final revision made to the demographic information was to include two scaling questions regarding satisfaction of participants' graduate program. This was to contextualize the data further regarding the participant's education and sense of preparedness. The dissertation committee also agreed that the use of the ProQOL measurement could assist with triangulation of the data presented by participants.

The use of the Qualtrics electronic survey software during the pilot study was found to be critical in saving time as well as allowing participants to receive a large amount of information regarding the study at once. For instance, respondents were able to review and accept the terms of the informed consent process through Qualtrics. In addition, participants completed the demographic and ProQOL measurement portions of the survey with immediate feedback of their results. Participants in the pilot study noted that receiving the ProQOL results was one of the most positive parts of the process.

Participants expressed understanding of the informed consent and overall use of Qualtrics. As result of this positive feedback, no changes to the Qualtrics web-based survey process were made.

Chapter Summary

In this chapter a review of the research questions and rationale for the chosen methodology were presented. A detailed explanation of CQR methodology including research team selection, data collection, and data analysis was described. The process of development and revision to the interview protocol was explained. Selection of the participants desired for this study was discussed at length. Results from the pilot study were presented with modifications to the study based on pilot and dissertation proposal seminar feedback. The chapters that follow include the results of the current study and a discussion of the implications and limitations of the study.

CHAPTER IV

RESULTS

In the current study, the researcher investigated the experiences of entry-level professional counselors working in community mental health (CMH) settings. The exploration included potential impacts to counselor wellness. Participants included only entry-level counselors with less than 2000 post-graduate clinical hours, which fell within a minimum of one year but no more than four years, within the community mental health context. In addition to interview questions the participants were asked to complete the Professional Quality of Life Scale (ProQOL). In this chapter the results of the current study are presented. Participant demographics are described first, followed by the results of the PROQOL. Finally, findings from the qualitative interviews are provided.

Description of the Sample

The current study included data obtained from 11 participants from the state of North Carolina who identified as working in community mental health settings with the credential of Licensed Professional Counselor Associate (LPCA) by the North Carolina Board of Licensed Professional Counselors (GS 90-336; 21 NCAC 53 North Carolina Licensed Professional Counselor Act, G.S. Article 24). All participants were recruited via email, word-of-mouth, or in-person at a state counseling conference. Participants were screened to ensure criteria for the study were met. Ten of the 11 interviews were conducted via online video conferencing and one interview was conducted in person.

Interview times ranged from 40 minutes to 1 hour and 20 minutes.

Socio-demographics

Age, gender, relationship status, race. Participants ranged in age from 25 - 43 with an average age of 32. Ten of the participants were female and one participant was male. Six of the participants identified themselves as single, one reported being in a committed relationship and four identified their relationship status as married. Eight participants noted race as Caucasian and three participants described their race as Black or African-American.

Education. All participants reported having graduated from a CACREP accredited Master's of Counseling program within at least one year and no longer than four years. The average time post-graduate was 26 months. The range of time since graduating with a master's degree was from 12 months to 52 months. The participants who reported a longer amount of time from graduation noted significant life events, which impacted their ability to begin or sustain work. Because of this difference in time, participants were required to have between 1,000 and 2,000 hours of post-graduate clinical experience ($M=1445$, $SD = 297$) Participants noted their satisfaction with their graduate program as "overall satisfied" (Satisfied: $n=4$; Very Satisfied: $n=6$; Somewhat Satisfied: $n=1$). No participants identified dissatisfaction with their graduate program.

Employment and funding sources. All participants identified that their positions were based in community organizations. Seven of the organizations were indicated as for profit and four as nonprofit. All 11 participants identified their organizations as accepting

Medicaid as a funding source. Five organizations were noted as receiving specific state funding that is tracked through an accountability process called Integrated Payment and Reimbursement System (IPRS). Private health insurance was identified for six of the organizations along with self-pay options for clients. Grant funding for client services was specified for five of the organizations.

Participants' length of employment at the current organization ranged from one week to three and a half years. Seven participants identified having been previously employed at another community organization prior to the current location. Four participants indicated that they had been employed only at the current organization.

Client Factors

Participants noted that on average they see 17 clients in one week ($SD=9.87$). The range of client contact was identified from six clients to 40 clients in one week. Client factors related to types of diagnoses can be seen in Table 1.

Supervision

All participants reported that they are receiving supervision as required by the North Carolina Board for Licensed Professional Counselors (NCBLPC). Supervisors are required to have at least five years of post-graduate counseling practice with at least two years post-licensure and a minimum of 2,500 direct client contact hours. In addition, supervisors are required to obtain the equivalent of a three hour graduate level course related to supervision (21 NCAC 53. 0209; G.S. 90-330(a)(4); 90-334(h), (i); 90-336(d)).

Table 1

Client Presenting Issues

Presenting Client Issue	Number of Participants Who Identified Working With Issue
Anger Management	11
ADD/ ADHD	10
PTSD	10
Anxiety Disorders	10
Depression	10
Trauma	9
Grief/ Loss	9
Substance Abuse	8
Suicide	8
Sexual Abuse	7
Rape/ Sexual Assault	7
Homelessness	6
Child Abuse	6
Domestic Violence	6
Bipolar Disorder	6
Psychosis	6
Addictions (other)	6
Personality Disorders	5
LGBT	4
Autism/ Asperger's	4
Disability Issues	4
Couples/ Family	3
AIDS/ HIV	3
Adoption/ Foster Care	3

Participants identified the credential of their current supervisors as Licensed Professional Counselor Supervisor (n=7), Licensed Professional Counselor (n=2), and Licensed Clinical Psychologist (n=2). Participants noted an average of four hours of formal individual supervision per month. This is consistent with the NCBLPC

requirement of one hour of supervision per 40 hours of clinical work. In addition, participants identified an average of four hours of group supervision per month, ranging from 1 hour to 10 hours in length.

Summary of Findings

Consensual Qualitative Research (CQR) methodology was utilized to examine the data within the context of the research questions for the current study. CQR provided a format for data collection and analysis that allowed for rigorous examination along with support and consensus from a team (Hays & Wood, 2011; Hill et al., 2005). The ability to come to consensus with a research team honored the philosophical differences present when interpreting data and allowed for a richer interpretation of the results (Hill, 2012). The research team for this study consisted of four members, which included three members to examine the data and reach consensus and one auditor to ensure accountability in the research process.

The research team developed a start list of potential domains to utilize during the coding process. The start list was based in the literature that best described entry-level counselors, counselor wellness, and community mental health. The start list domains included, (a) career choice, (b) organizational factors, (c) client factors, (d) self-care/wellness, and (e) supervision. Once data review began another domain developed related to job preparation. Job title or role and ProQOL experience were added to the final domain list for ease of analysis.

Labels were assigned to each category to demonstrate the frequency with which participants presented a particular theme. For this study, a label of *general* was used when the category was marked in 10-11 cases. The label of *typical* was assigned for categories marked in 5-9 cases, and *variant* was assigned for categories marked in 2-4 cases. *Rare* categories, or only represented by one case, were not included in the results of this study. Table 2 shows a summary of the domains, core ideas, categories and frequency labels found through the analysis of the data.

The research questions directed the interview questions for this study. The overall goal of the study was to explore the experiences of entry-level counselors in the setting of CMH. Participants were asked to complete the ProQOL scale prior to the interview process. Participants were given the opportunity to ask questions about the measurement and were then asked to provide feedback regarding their experiences taking the measurement.

Participants expressed significant factors that seemed to impact them within the context of CMH settings. Overall, participants were eager to share their thoughts about their work. During interviews, participants first identified their job title or role within the CMH setting. The most common title used was *therapist*. In addition some participants reported that their title correlated with their role such as *assessor* or *intensive in-home lead*. Only one participant identified that their title included the word *counselor*. The full list can be seen below in the section that addresses job titles.

Table 2

Domains, Core Ideas, Categories, and Labels with Participant Examples

Domain ¹	Core Idea (identified participant) ²	Category ³	Participants ⁴	Label
ProQOL	“made me dig deep into how I felt about the field.” (5) “my scores were inaccurate of how I felt at my last job.” (2) “brought up what I need to work on.” (8)	Reflective Timing Awareness	2,3,4,5,6,10,11 1,2,6,8,9,11 5,8,9,11	Typical Typical Variant
Career Choice	“chose it because I couldn’t find a job.” (8) “have a heart for marginalized people.” (9) “actually go into people’s homes.” (2) “middle school.” (1) “my own energy level.” (3) “ I found that I was good at it.” (2) “my dad was a school counselor and I was not inclined to do that.” (6)	Limitations Values Setting Population Personality Personal Abilities Personal Experiences	1,4,5,6,8,9,11 1,4,7,8,9,10,11 1,2,3,6,8 1,2,3,10 3,7,10 2,3,10 5,6	Typical Typical Typical Variant Variant Variant Variant

Domain	Core Idea (identified participant)	Category	Participant	Label
Organizational Factors	“the focus was so much on paperwork.” (1)	Administrative Burden	1,2,3,5,6,8,9,10,11	Typical
	“following our state standards.” (8)	Accountability Practices	1,2,3,5,6,8,9,10,11	Typical
	“we have somebody who does our billing for us.” (3)	Administrative Support	1,2,3,4,5,6,7,8,10	Typical
	“the agency has their own treatment manual and you have to choose interventions from that.” (6)	Flexibility/ Rigidity	1,2,3,5,6,7,8,9,11	Typical
	“I didn’t really feel safe on the job.” (6)	Safety	3,6,11	Variant
	“if they don’t show, we don’t get paid.” (5)	Salary	5,6,11	Variant
	“having the support that I have on my team.” (7)	Collegial Support	3,5,7	Variant
Client Properties	“A lot of people have Child Protective Services involvement in their cases.” (2)	Complexity	1,2,3,4,5,6,7,8,9,10,11	General
	“poverty, poor resources, poor supports.” (9)	Access to Resources	1,2,3,4,5,6,7,9,11	Typical
	“crisis intervention, suicidality, some with homicidal ideation.” (2)	Acuity	1,2,3,5,8	Typical
	“not voluntary.” (10)	Mandated	1,10	Variant

Domain	Core Idea (identified participant)	Category	Participant	Label
Self-Care/ Wellness	“partner, massages, singing in a choir.” (2)	Strategies	1,2,3,4,5,6,7,8,9,10,11	General
	“somebody else’s crisis always seems to take precedence.” (10)	Threats	2,3,4,5,6,8,9,10,11	Typical
	“taking time to myself when I get home.” (6)	Boundaries	1,3,4,6,7,8,10,11	Typical
	“kind of puts things in perspective for me.” (1)	Perspective	1,2,6,7,11	Typical
	“I try to let it be with the client.” (3)	Cognitive Appraisal	3,7,8,11	Variant
Clinical Supervision	“really supportive and helpful.” (2)	Supportive	1,2,3,4,5,6,7,8,9,10,11	General
	“she may be supervising too many people.” (5)	Accessibility	2,4,5,6,7,8,9,10,11	Typical
	“breaking things down into how I could do things better.” (2)	Clinical Decision	1,2,6,7,9	Typical
	“greater supervision experience if somebody in the community were my supervisor.” (3)	Connect to Community	3,6,7,8,9	Typical
	“might have to quit because I did not think I could pay for it.” (9)	Financial	1,4,8,9,11	Typical
	“making sure I’m getting that work/life balance down.” (1)	Encouraging Self-care	1,2,3	Variant
		Mode		
		Role Conflict	1,6,8	Variant

	“with Skype, I never felt like he really knew me.” (6)	Modeling	1,5,6	Variant
	“kind of had this power struggle.” (1)	Supervisor Identity	2,7	Variant
	“also modeling self-care herself.” (2)		2,6	Variant
	“neither one understood counselor identity.” (6)			
Domain	Core Idea (identified participant)	Category	Participant	Label
Preparation	“I had no idea. I didn’t know how to navigate this.” (1)	None	1,2,4,5	Variant
	“knowledge that I have from my graduate program.” (7)	Graduate School	6,7,8	Variant
	“getting a lot of support and validation in my internship.” (2)	Internship	2,3,5,6,7	Typical
Counselor Factors	“I’m not an outgoing person.” (10)	Personality Traits	1,2,9,10,11	Typical
	“you learn. You learn as you go along.” (11)	Self-efficacy and maturation	4,5,9,11	Variant
	“authentic and genuine.” (3)	Ethics and Values	3,7,11	Variant

¹ Domain – broader categories developed from literature and emergent from data

² Core Idea – raw data quoted from participant interviews with identified participant who provided data

³ Category – more detailed data grouping using descriptive words to explain the category

⁴ Participant – identified participant who noted presence of category in interview

Prior to the interview, participants were asked to complete the ProQOL scale. During interviews participants were asked to discuss their experiences taking the measurement. All participants completed the scale and none had additional questions for the interviewer. Seven of the participants reported that the experience of taking the measure created a sense of reflection about their work in the counseling field. Four participants identified that the measurement brought a sense of awareness to their personal functioning in the field. Six of the participants noted that they believed their scores might have been different if they had taken the measurement at a different time. Most noted a previous job where they felt less well or experienced what they considered a greater sense of burnout. Whereas none of the participants identified burnout or secondary traumatic stress on the measurement, all participants expressed an awareness of these terms and discussed their experiences. Providing the participants with a measurement such as the ProQOL seemed to contribute a starting point for discussing their experiences in the CMH setting.

Participants expressed various reasons and circumstances for their choices to work in the CMH setting. The relevant interview question designed to collect information on their career choice did not refer to the field of counseling in general, rather the specific setting of CMH. Seven participants identified that they felt limited in their ability to secure employment in other settings. Several noted that without an independent, unrestricted license they were unable to find employment in other settings. In addition, many of the same participants noted that the organization and setting did seem to align with their values of helping others. More specifically, five of the participants indicated

that they chose the CMH setting or organization they worked with because of a service delivery model or the client accessibility that was offered. Four participants specifically identified that they preferred a certain population or age group met by the setting or organization. Further, some participants identified that their personality or abilities impacted their choice of setting.

One of the most prominent discussions with participants occurred around the issues of organizational factors. Participants described their experiences as entry-level counselors in the CMH context most vividly in this domain. Nearly all of the participants (n=9) reported that they experience a heavy administrative burden in their work. Conversely, nearly all of the participants (n=9) identified that they do have some type of support in their organizations to assist with administrative duties. The most typical language used to describe the support was *utilization management*. The Utilization Review Accreditation Commission (URAC) defines utilization management as, “the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan,” (“URAC - Health Utilization Management,” n.d.) Participants referred to this mainly related to client authorization for services and billing processes. This support did not eliminate the impact reported by participants related to the significant amount of paperwork involved in CMH settings. Typically, participants identified that they felt there were rigid expectations in their work that stemmed from both organizational expectations as well as from state or other compliance or accountability practices such as Medicaid, various funding sources, or other accreditation organizations. A few

participants identified that safety concerns were a factor that impacted them. Examples were given that demonstrated aggressive clients along with unclean working environments. Some participants noted that salary was a concern for them due to being contracted with organizations rather than receiving a consistent salary. Participants described the nature of contract work meant that pay consistency was varied due to lags in billing cycles or unreliable client adherence which limited billable hours or because of lack of benefits such as sick days or vacation time. This was reported as a hindrance at times to effective client care or self-care.

In addition to organizational factors, participants revealed that the complexity of their client caseloads seemed to impact them. All participants identified that they work with many complex issues in client care. These complexities were related to diagnoses and environmental factors for clients. The most typical client issue that participants identified as impacting their ability to effectively do their jobs was that of client's limited access to resources. This included housing and general basic needs. Nearly half of participants identified that they work with high acuity levels and responded to client crisis. A few participants also noted that mandated clients impacted their work as well.

Participants were asked to describe their experiences with maintaining wellness or self-care. All participants noted specific strategies that they used to cope effectively with work challenges. Many identified things such as exercise, spirituality, hobbies, and time with partners as being helpful to their self-care. Nearly all participants described something that was a potential threat to their wellness. These threats to wellness tended to be related to paperwork and changes in the mental health delivery system. Participants

typically responded to these threats by again exploring self-care strategies or creating boundaries that appeared to be cognitive boundaries (i.e., differentiating thoughts of self from client), client boundaries (i.e., taking phone calls or limiting client interaction), or administrative boundaries (i.e., completing paperwork). In addition, a few participants described an appraisal that seemed to occur with their work. This cognitive appraisal seemed to set a further mental boundary for them and pointed to their ability to think about their work in a different or meaningful manner. Further, participants reported that their work offered them a different perspective on themselves and their clients. This surfaced as a self-care or wellness mechanism for participants in the setting of CMH. For instance, one participant described this perspective as being grateful for what personal resources they have.

Clinical supervision was another part of the reported experiences of entry-level counselors in CMH settings, and it brought up multiple categories. All participants were involved in regular supervision as required by the board and many identified additional factors within supervision that were important to them. All participants identified that a supportive relationship was of primary importance.

In addition to support, participants noted the significance of having a supervisor that is accessible to them. Some participants identified that supervisors had been too busy to provide consistent support whereas others noted that they had somewhat consistent supervision. Participants identified that some of the accessibility was related to the role that the supervisor had in their setting. Nearly half of participants reported that there were at times a sense of disconnect with their supervisor to the CMH setting. This occurred

most frequently when the supervisor was not based in the participants' organization. With this disconnect some participants indicated that they had experienced some conflict with their supervisor when the role of clinical versus administrative supervisor was differentiated.

Participants discussed how the financial burden of paying for their own supervision impacted them. Five participants identified this as a burden and noted some strain due to the lack of financial support in the CMH setting. One participant even identified that the burden had been so much at one time that they considered stopping licensure supervision.

Supervision that included clinical decision-making was typically important to participants. A supervisor that offered support around self-care and modeling self-care was also noted as an impact for the counselors. Finally, three participants identified that the mode of supervision (either in-person or technology assisted distance supervision) was significant in their experiences of supervision in CMH settings. However, these participants noted less personal contact and relationship in these distance situations.

Preparation for the work roles via graduate education was another domain that surfaced throughout the analysis. Participants identified that internship experiences were the most typical source of preparation. Participants seemed to differentiate the internship experience from their formal graduate school training. Whereas internship was a typical response, only three participants noted graduate school as preparing them for CMH work. Four participants identified that nothing during their graduate education in counseling

prepared them for the work they are doing. Much of the discussion about the lack of preparation was related to the administrative components of the CMH work.

Finally, participants began to describe factors about themselves that impacted their experience of working in CMH settings. There were no questions that specifically addressed personal factors for counselors but through the analysis it became clear that counselor factors could not be separated from the experiences reported. Personality traits of participants were the most typical factors reported. These included characteristics such as self-descriptions of being a compassionate person or not being an outgoing type of person. In addition, factors such as values and ethics seemed to be important to counselors in their work in CMH settings. Respondents also reported a sense of self-efficacy or maturation as a counselor since their graduation.

Overall, participants were descriptive in their experiences related to CMH settings. They identified multiple themes that reflected their unique experiences of being an entry-level counselor. Specifically, wellness and experiences of organizational and supervision factors seemed to produce the most significant reactions for participants. This study did not generate many general categories, rather many experiences were similar but a large number of categories were unique to individual participants. Those that were universal for participants included the complexity of client cases, self-care strategies, and the need for a supportive supervision relationship. The highest frequencies of typical responses were generated within the organizational factors domain. It is clear that entry-level professional counselors have many responsibilities and needs within the context of CMH related to organizational demands, client issues, and support.

ProQOL Results

Prior to the interview portion of the study participants were asked to complete an electronic survey. In addition to basic demographic questions the survey included the ProQOL Scale. The scale helped to determine compassion satisfaction, burnout, and secondary traumatic stress. Low scores are desirable for both the burnout and secondary traumatic stress scales whereas the desired level for compassion satisfaction is average or high. The subscale values can be seen in Table 3 and participant results of the ProQOL are displayed in Table 4.

The inclusion of the measurement was to provide a baseline of functioning and general context related to the professional quality of life of the participants. In addition, the experience and results of the ProQOL created a lead in to the interview questions that allowed participants to explore their current perceived level of satisfaction with their jobs.

Overall, participants scored either low or average on all subscales. This is not unusual or unexpected for counselors compared to the general population (Lawson & Myers, 2011; Sprang et al., 2007). No prior research was found that specifically identifies the scoring for new helping professionals. The results will be included below along with other domains and categories for further details of the participant interview process.

Table 3

ProQOL Subscales of Compassion Satisfaction, Burnout, and Secondary Traumatic Stress

<u>Sum of Subscale</u>	<u>Score of Subscale Equals</u>	<u>Level</u>
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Table 4

Participant Scores of ProQOL

	<u>Compassion Satisfaction</u>	<u>Burnout</u>	<u>Secondary Trauma</u>
Mean Score	49.9	20.09	18.27
Standard Deviation	5.7	5.1	3.4
Level	Average	Low	Low

Domains, Core Ideas, and Categories

The research team identified eight domains through the process of transcript review and consensus meetings. This list differs from the start list noted above in that the final list is a result of consensus and emerging data during the initial process of reviewing participant responses. The final domains were identified as: (a) job title or role, (b) ProQOL experience, (c) career choice, (d) organizational factors, (e) client factors, (f) self-care or wellness, (g) preparation, and (h) supervision. Each of the domains along with related core ideas and categories are described and discussed below.

Example statements from general, typical, and variant categories based upon frequency of each domain are included. Each core idea and category is explained and

described in order of label from general to variant. Although variant categories are often excluded in reports of CQR results they will be included here for the purpose of later discussion. Results that were found as rare will not be discussed.

Job Title or Role

The domain of job title or role primarily provided the CQR team with descriptive data. Job Title or Role is simply the title used by the organization or the role that the participant identified. These are provided here because the title of a counselor may be an important part of a counselor's experience. It also shows the variations of titles and roles that entry-level counselors are taking on following graduate school.

These various titles are simply listed here with no repetition as follows: (a) Outpatient Therapist, (b) Community Support Team, (c) Community Based Counselor, (d) Therapist, (e) Intensive In-home Team Lead, (f) Early Childhood Mental Health Consultant, (g) Vocational Specialist, (h) Clinical Assessor, (i) Licensed Professional Counselor Associate.

ProQOL

The Professional Quality of Life Scale was administered to all participants prior to interviews. The CQR team treated the domain of ProQOL in a similar manner as the other domains for the purposes of analysis. The ProQOL was given to participants primarily to assist with contextualizing the participants and providing a baseline of experience that related to compassion satisfaction, burnout, and secondary traumatic stress. This inclusion of the results in the interview portion of the study served as an introduction to the interview questions. It allowed for participants to further explain or

question their results. In addition, it provided useful information regarding their experiences of taking this measurement. Within the domain of ProQOL experience, three categories surfaced: timing, reflective, and awareness. Core ideas were related to the experience of taking the questionnaire rather than the results of the measurement. Results of the measurement can be found above in Table 4.

Timing. Six of the 11 participants noted that the timing of the measurement was significant in some way. This category simply referred to a response from the participant related to the timing of the administration of the instrument in relation to their current or previous work experiences. Participant 1 reported, “if you had asked me this maybe three months ago, when I was in my last job, I probably would have had a completely different answer because it was difficult then.” Comparably, participant 2 stated, “I felt like my scores were a little bit inaccurate of how I felt at my previous job.” Participant 6 also noted that her scores would have likely been different if they were at a previous job. Participant 8 noted, “I really enjoyed getting that feedback and kind of seeing where I was maybe a month or two months ago and then seeing where I’m at now.” Participant 9 expressed concern that her results were not going to be normal based on experience at a previous job. Participant 11 also noted a potential difference in scores since her previous job role. She stated “my burnout level probably would have been a little higher then. A lot higher, yeah.”

Reflective. When participants were asked if the measurement brought up any thoughts or feelings several had a specific response that was classified as reflective. Participant 2 expressed surprise at her score in the following statement:

I guess I was just surprised that when I looked at the scale as to what was normal or okay, I fell into that range for everything else. I was like, Oh! I am doing better than I thought I was.

Participant 3 indicated reflection on things that keep them well. She reported “I’m answering these questions and I feel very fortunate to not work in the county where I live.” Participant 4 indicated that taking the measurement “really made me think about my actions and how I allow certain things to affect me.” Participant 5 noted “it really made me have to dig deep into how I felt about the field.” Participant 6 stated “it is nice for me to kind of reflect on how far I’ve come.” Participant 10 reflected about his answers and noted “I checked off a lot of things that didn’t bother me and it almost seemed like some of them should have.” Participant 11 indicated that the reflection was helpful and reported, “sometimes I get tired, and sometimes I get a little burnt out and frustrated with it, but overall it made me realize that I really do like what I’m doing.”

Awareness. Similar to reflection, participants seemed to identify that taking the measurement created some awareness of their experiences of wellness and potential impacts to that wellness. Participant 5 noted, “it made me realize how in most cases, I am able to leave my work at the office.” Participant 8 indicated awareness of areas that they would like to work on in her development. Participant 9 reported that this experience created awareness of a need for effective boundaries. Participant 11 indicated an awareness of enjoying the work she does.

Career Choice

Within the domain of career choice participants included seven factors that impacted their choice to work in community mental health organizations. This domain

was intended to capture the choice of participants to enter into CMH specifically rather than the counseling field overall. These responses included core ideas: (a) limitations due to licensure status, (b) setting, (c) population, (d) personal abilities and experiences and (e) values.

Limitations. One of the two most prevalent factors that participants noted for choice was limitation. Of the 11 participants, 7 cited limitations due to licensure level and experience level. In general participants identified feeling that they did not have a lot of choice for the setting since CMH allows for associate license billing. Four participants identified that they could not find jobs in other settings. Participant 1 noted that they had even returned to school for an add-on certificate due to inability to find a job. Participant 6 stated, “I would love to do private practice one day but I don’t feel like I know how to start my own business or have the resources to feel comfortable doing that.” Participant 9 stated:

At my level of not being fully licensed, my impression is that you don’t have a lot of options. You basically have your MCO [managed care organization], and your family preservation, maybe one or two others and if you can’t get a job in of those three to five places, or a methadone clinic, you’re out of luck.

Participant 11 stated:

I started out finishing up my grad program and I did not want to work in community mental health. I heard horror stories. I did not think I could work with children. I did not want to go into anyone’s home. I was praying and crossing my fingers for more private practice, group practice, and office setting work. My internship I did at the counseling center at my university. So ultimately I wanted that type of setting. As an entry-level counselor those types of settings aren’t readily available. So I had to go start my work in the field.

Values. In addition to limitations participants identified that values around helping others was important in their experiences of working in CMH settings. Seven of the 11 participants noted values in some way impacted their choice to be in a CMH setting. Participant 1 noted the value of freedom to be in the community. In addition, participants 4, 7, and 9 noted that they valued being able to help people. Some pointed to the value of helping as an overall career choice as well as within the specific CMH setting. Participant 9 identified that she has “a heart for marginalized people.” Participant 10 noted that the agency in which he worked aligned with his value to “catch them younger and have a better outcome.” Participant 8 noted that even though the choice to be in CMH was due to limitations she found that the particular agency held similar values. In spite of limitations expressed, participant 11 stated:

But then when I started working for this current agency it became a better experience because I could become more of an independent counselor and do things the way I saw fit to do them and create a very healthy environment for myself and the client. I started out not wanting to be in community mental health at all, but as time has progressed, I have learned to love it because I see the need in the community and I see that we can really do valuable work when they go in the home. I know that work would not be done if that type of client had to come to us.

Setting. Participants explored how the specific setting or model of service provision impacted their experiences of career choice in CMH. Specifically, five of the respondents noted something in particular about the setting that they liked. Participant 2 noted that she “like the models...where you actually go into people’s homes.” Similarly, participant 3 enjoyed the ability to “meet them on the front porch at their houses where

they're comfortable." Participant 8 identified that one of her values was to keep families together and to do this involved traveling to six different counties in this setting.

Participant 8 noted that this setting "keeps me working for the agency in the community that I work for." Participant 6 identified that in a previous role the impact of the community setting was having a detrimental effect. This influenced the choice to transition to a different setting. Participant 6 also stated that the previous setting of intensive in-home "just about killed me." The current setting for participant 6 was in an office.

Population. Participants discussed overall the setting and types of clients with whom they worked. However, only 4 of the 11 participants specifically identified that the population group they worked with was chosen due to interests. Participant 1 was adamant about working with middle school clients. Participant 2 expressed that she "really liked the client interaction, working with people with psychotic disorders and really severe mental illness." Similarly, participant 3 noted that she enjoyed working with kids and specifically identified that the population was appealing because she preferred "equine therapy...outdoor stuff and meeting kids at school." Participant 10 was clear about his preference of working with "older adolescents and the early adults."

Personality. Only three of the participants discussed experiences that seemed to reflect personality qualities that impacted their decision to work in CMH. Participant 3 noted the CMH setting as a good fit because "my own energy level. I like to move. I like to go." Participant 7 related personality to the overall choice of counseling as a career as well as the CMH setting and stated "I knew there really was no other work I wanted to

do. I love talking to people.” Participant 10 expressed that it seemed to be a part of his personality and that it was a natural part of him.

Personal abilities. Three of the participants noted personal abilities as impacting their choice for CMH settings. One participant noted specifically that she has equine therapy interests and abilities. Participants 2 and 10 noted more generally that they seemed to have natural abilities for counseling work in their references to how others tended to approach them for support throughout their lives.

Personal experiences. Finally, two participants related personal experiences as contributing to their decision to work in CMH and counseling in general. Participant 5 identified significant painful experiences as part of her personal past. She noted, “I chose to go into mental health because I feel like I am the epitome of a wounded healer.” Participant 5 stated “my dad was a school counselor and so I was not inclined to do that.”

Organizational Factors

Participants were asked about their experiences within the CMH organization itself. This domain included larger factors such as policy or state mandates in addition to the organization’s specific culture or demands. Respondents identified characteristics related to the work setting, policies, and procedures. These were factors primarily related to administrative duties and support within the agency as well as accountability practices set up by compliance related organizations or the agency within itself.

Administrative burden. One of the most frequently cited experiences in the CMH setting was administrative burden or paperwork related concerns. All 11 participants acknowledged that paperwork is a part of their experience, whereas 9 of the

11 participants identified this as a negative experience that impacts them in their work.

Participant 1 indicated that in a recent previous job the focus was on paperwork rather than client care. She stated:

The extraneous work was part of the reason why I felt I had to leave, because it was paperwork, paperwork, paperwork, paperwork, paperwork. And I did not feel that I was using my counseling and therapy skills to the extent that I should have been.

Participant 2 identified the administrative burden related to the amount of clients seen.

She stated:

When you multiply what you do for one client times multiple clients and they're coming in at different stages. Each week you have somebody that you are doing an intake for and then somebody else is going off the team so you have to do a discharge and all the paperwork and all that.

Related to the administrative duties involved in CMH work, participant 3 noted, "I love feeding the horses and I really, really don't like all the paperwork." Participant 5 indicated "the paperwork is atrocious." Participant 6 described the paperwork for an intensive in-home position as "like having a second job." Participant 8 described the experience as follows:

Paperwork is always a struggle for counselors who work in the community especially. My current role has a lot of documentation. I do clinical assessments so it's a lengthy document. I feel like I spend as much time working on the document after I do the assessment as when I'm with the family doing the assessment.

Participants 9, 10, and 11 also noted that paperwork and documentation as part of the organization experience as negative. Participant 9 indicated that "paperwork was seventy-

five percent, it felt like.” Participant 10 identified that in addition to the strain of the required paperwork “documentation seems a little inefficient in the way it’s done.”

Participant 11 referred to the paperwork as a “headache.”

Accountability practices. To further describe the documentation and administrative burden, participants described experiences with accountability practices. These included specific reports or documentation that are implemented by the state or local governing organizations as well as within the organizations themselves. Nearly all the participants identified these components as impacting their work in some way. In describing their experience with Medicaid funded client accountability, participant 1 noted “it was almost like Common Core with schools, when you are teaching toward the test. I felt like I was working toward the paperwork.” Participants 2 and 3 both noted that there was a lot to track through approval of the Managed Care Organization (MCO) that funds their client services. Participant 2 identified that one of the difficulties with the MCO is that paperwork has increased since the process of service authorizations had changed. In addition, participant 3 noted the difficulty to track the number of sessions remaining with the paperwork that is required for the MCO. Participants 5 and 8 identified specifically the state paperwork required both person-centered plans and treatment plans. Participant 6 reported that they had “a lot of paperwork that wasn’t necessarily required by the state but that the agency required.” Participant 9 indicated “there was a huge amount of policies and procedures and paperwork.” Participant 9 added:

All the paperwork you had to do, the NCTOPPS [North Carolina Treatment Outcome and Program Performance System] and the reassessment of some of the plans. There was just constant paperwork. Sessions were really about either just real basic checking in with people or with paperwork.

Participant 10 related the documentation and accountability to compliance with Medicaid funding.

Administrative support. Whereas a common concern with documentation and administrative burden surfaced with participants, most also identified that they had some type of administrative support in place. Many of the participants identified that there is a specific person or department in the organization that handles billing components for them. Participants 3, 6, and 10 specifically indicated that as long as they do the documentation for client services there is a billing support piece. Participant 1 referred to this support as “the business side.” Participant 7 indicated that there is an assistant to support them with authorizations. Participant 2 noted that she is responsible to “provide all our clinical evidence for an authorization and put in a lot of the information like the justifications for things but somebody in our office actually handles inputting it into the system that goes to the MCO [Managed Care Organization].” Similarly, participant 5 noted “we do the paperwork, we send it over to this particular person and then they take care of submitting it to the MCO. We don’t have to worry about that part, which is helpful.” These are all components of billing under a Medicaid system. Participants 2, 4, and 8 noted specifically that their support is under the title of utilization review. Participant 6 used the title “billing specialist” to identify her support. Participant 7

labeled her support as “program assistant”. Participants 1, 3, and 10 did not use any specific title.

Flexibility or rigidity. Another factor that participants identified as impacting their experiences in CMH was that of rigidity or flexibility in their organization. The responses ranged from specific technique requirements of the organization to the amount of time that they had to complete paperwork or documentation. Nine of the 11 respondents noted some effect related to rigidity or flexibility. Both participants 1 and 6 noted that the organization required a specific technique or set of interventions that are preapproved. Participant 6 stated:

They have their own treatment manual and you have to choose interventions from that which to me coming right out of grad school is like, man, I want to try these theories that I’ve learned but I was specifically told that talk therapy was not evidence-based and that it wasn’t shown to work and that I just couldn’t use it.

Participant 8 identified that the organization required her to turn in paperwork within 24 hours of service delivery. Similarly, participant 5 noted that she has 24 hours to submit documentation as well. In addition, participant 5 reported, “they have these punitive measures in place where your pay will significantly drop if you don’t get it in on time.” Participant 2 noted that there was limited flexibility for paperwork as well. She identified that the organization demanded that the full-allotted time was given to clients and did not allow for paperwork during paid service hours. She stated “we get four hours a week with the client, we were supposed to spend that full four hours with the clients. If there was paperwork to do outside of that it was on your own time.” Participant 3 indicated that there is rigidity in the format that must be used to submit billing for services. Participant

7 noted that there is limited flexibility regarding the types of client she is assigned. She reported, “It’s really up to my team lead and the psychiatrist who they bring on and who they feel is appropriate for the team.” Participant 9 identified that she “felt like the whole system is just designed to make you whip through people and see them as fast as you could, and do all the paperwork that you had to do.” They noted this focus on the quick turnaround for client services. In addition, participant 9 noted that there are service definitions that must be followed for service delivery. Finally, participant 11 identified that there was rigidity in her demand to be accommodating to client schedules rather than to her own needs.

Safety. Whereas safety was not a major factor noted as impacting counselor wellness, it was reported by three of the participants as a concern. Participant 3 noted that there are often considerations of safety since the services are delivered in the community. She identified multiple stories of clients who had thrown chairs, used a hammer to incite intimidation, and generally going into locations that are unknown to the counselor. Participant 6 noted that she had also experienced unsafe conditions with unpredictable clients. She identified one particular client who had a history of being aggressive toward the counselor and who had been known to pull a knife on people. This participant reported that the safety conditions were a contributing factor of leaving that specific job. She stated:

That was another reason why I left because I didn’t really feel safe on the job and I had expressed concerns about safety with working with this client because she had a long history of pulling knives on people and hitting and punching peoples. I didn’t get a lot of support with that and then ultimately was attacked.

Participant 11 noted that one deterrent from working in the community was safety considerations. She noted that there was awareness of “fights in the home while the counselor was present.” In addition, this participant discussed the general unpleasant working environment in which, “bugs, bedbugs and things are in the homes.”

Salary. Three participants also identified that salary concerns were of issue for them in their organization. Participant 5 identified that if she is not seeing a client there is no pay. They reported:

When we see a client we get paid for seeing that client. If we have them booked and they don't show, we don't get paid for that. There is no salary. We're always trying to get people in our chair.

Similarly, participant 6 noted that there was a no pay for clients who did not show up or cancelled. Participant 11 identified that there is no salary and indicated that at times there is a decision that must be made regarding time spent with clients and completion of paperwork for the organization due to the money. She stated, “so if I'm spending time for the business doing paperwork, but I'm not making money at that point in time, it's frustrating if I have to swap one for the other.”

Collegial support. Three participants identified that they did experience collegial support within their organizations. This was noted as supportive interactions with other co-workers or therapists in the same environment. Participant 3 identified therapist interaction and participant 5 indicated other therapists and co-workers were supportive. In addition, participant 7 identified that there was a sense of team support.

Client Properties

Participants were asked about the types of clients they work with in their roles. This domain encompassed components of client cases that participants reported as impacting treatment planning and service delivery.

Complexity. All 11 participants identified that they have complex caseloads. Complexity involved the various diagnoses as well as multiple social environmental factors that clients present which included compound issues or projected treatment plan needs. Related to social factors or complex situations that participants reported with their clients, participant 1 noted that many of her clients were dealing with family of origin separation issues and noted “a variety of sorts, some of them more just like parents taking out [legal] charges for discipline, with issues at home, some were truancy, some were that they had actually committed a crime.” Similarly, participant 2 identified that in her caseload,

A lot of people have Child Protective Services involvement in their cases. It is not necessarily that there is an abusive situation, but they’re homeless or moving a lot and they don’t have enough money to feed their kids or clothe them properly so CPS is involved.

Participant 3 also identified family separation concerns with her clients and also noted domestic violence situations and the need for clients to be in protective shelter.

Participant 4 also noted that many clients are facing divorce or family disruption concerns. Participant 5 reported that her clients also face family disruption along with environmental needs. She stated:

A lot of our children are young, black children in single parent households. A lot of them live in not the best neighborhoods. They don't go to the best schools. Overall they have pretty shady environments, which makes it difficult to work with them too.

Participant 6 identified that many of her clients were in foster care or working toward reunification with their families. Participant 7 identified that the complexity of her caseload tends to be associated with the diagnoses related to severe and persistent mental illness. Participant 8 identified that in her work with primarily families, the complexity stems from both trauma history as well as legal issues. Participant 9 noted many different diagnoses that impact her client complexity levels. Participant 10 noted that trauma history and behavior as impacting the complexity of his cases. Specifically, he stated “some of the stories can seem pretty unbelievable and remarkable at the same times because some of the things that the kids say they’ve gone through you just wonder how they’re still functioning at all.” Participant 11 identified that family issues seemed to lend to the complexity of her cases as well. She specifically identified things such as lack of structure in the home, blended families, and multiple caregivers as impacting their clients.

Access to resources. To further add to the complexity of cases, participants identified a theme that client access to financial, educational, or service-oriented resources was a factor that impacted their work. Many participants identified explicitly that homelessness is a concern for their clients. Participant 1 noted that there was often a need to deal with basic needs for clients before addressing therapeutic issues. Participant 4 similarly discussed the difficulty of balancing the basic needs of clients with the

therapeutic presentation and coping skills for clients. Participant 2 noted that clients face a lack of resources by experiencing homelessness or a lack of financial resources to feed or provide basic needs for their families. Participant 3 identified that when her clients present with homelessness or a lack of basic resources there is a tendency to supplement that personally. She stated:

One of the other things that I tend to do with these women is I tend to bring food. I had some lotion in my care, and last week it was really cold. My hands were really dry and I put some lotion on and right before I got out of the car to go see this one I said, "I wonder if she would like some?" I took that lotion in with me instead of doing it in the care and leaving it there. I don't want to say it is a goodwill, but it's almost a goodwill.

In addition participant 3 noted that there are just not many available resources provided in the community to assist clients to meet basic needs once homeless or leaving a shelter environment. Participant 5 reported that homelessness is a major concern along with lack of financial resources that could lead to homelessness for clients. Participant 6 reported that there are multiple outside factors that impact her clients' functionality. Whereas participant 6 did not specifically indicate homelessness, she did note lack of financial resources and a rural location as impacting client access to needed resources. Participant 7 stated:

It's really hard sometimes especially with a lot of my homeless clients. It's so hard to just drop them off at the end of the hour session. It's like well; you've talked about all your problems. Well, now you're back into it.

Participant 9 also reported working with many clients who experienced poverty, lack of resources, and poor supports. Participant 11 identified homelessness or home

displacement as an issue. She further indicated that this displacement directly impacts service delivery in that she is responsible for following that client to the new location as best as possible.

Acuity. A typical factor that arose regarding impact of client properties on participants was acuity or crisis needs of clients. Acuity was conceptualized as a sense of crisis or high level needs such as suicidal ideation of a client or some type of emergent situation, which required counselor response. Five of the 11 participants identified some level of acuity in their client caseloads. Participant 1 noted that clients may become suicidal or self-harming. Participant 2 reported that crisis intervention is a regular part of service delivery and noted that clients may be suicidal or even present with homicidal ideation. Participant 3 reported that there are often dangerous clients with whom she works. Participant 5 reported that with the service of intensive in-home there are “a lot of crises and emergencies.” Participant 8 noted that there is a sense of crisis with client experiences of habitual trauma and juvenile justice.

Mandated. Participants 1 and 10 indicated that their clients were not receiving services voluntarily and that this impacted their ability to work with the clients. Participant 1 specifically discussed mandated in-home services. She stated “they just didn’t want you to be there at all and they were forced into it because it was court mandated, and they didn’t want to be there.” Participant 10 stated “a lot of them don’t think they have a problem and can be reluctant to discuss anything so it takes a little while to get them going.”

Self-Care or Wellness

Participants were asked about ways in which they effectively deal with stressful client issues or other professional impacts. Many participants noted specific strategies or activities that they utilize to manage stress. Some participants were able to identify aspects of their practice or organization that may be a threat to their sense of wellness and self-care. Participants also began to describe ways in which they utilize cognitive strategies or boundaries to manage the impact of the work they do.

Self-care strategies. All 11 participants identified some type of activity that they utilize to practice self-care. Participant 1 noted things such as playing with her dog, hiking, and having visitors over as effective self-care strategies. Participant 2 identified spending time with a partner, massages, and singing in a choir as effective. Participant 3 identified that hobbies and expressive activities are important in her self-care. Participant 4 cited faith and prayer as primary for self-care. Participant 5 reported that talking to friends, working out, reading, and spirituality are important to her. Participant 6 noted her dog, her partner, walking, everyday activities such as making dinner and social media are effective wellness strategies for her. Participant 7 identified exercise and having personal support. Participant 8 noted that expressive activities such as dance, scrap booking, and journaling are important along with acupuncture as self-care strategies. Participant 9 also noted that spirituality is an effective strategy. Participant 10 noted that exercise, yoga, Tai Chi, and meditative practices are important to him. Participant 11 cited the need for taking breaks throughout the day as well as physical activities and spiritual activities as important for self-care and wellness.

Threats to wellness. Nine of the 11 respondents noted that there were particular things that impacted their self-care or wellness. These responses ranged from issues with paperwork and administrative demands to client issues. Participant 1 indicated that administrative requirements threatened her sense of wellness. She stated:

At the beginning of the week I felt vastly different than I did by the end of the week because I would be doing notes and paperwork until two or three in the morning and then getting up and seeing clients. At the beginning of the week I would have slept all weekend and then started my week. Then, as I got toward Friday I'd be dragging and sometimes I couldn't schedule clients in the morning because I was so tired.

Similarly, participant 6 noted the administrative burden was a threat to wellness and said "I was always doing it at home at night and waking up early to do it so it really was draining." Participant 5 noted that the climate of CMH is a threat to wellness for her. She reported:

We have had three Managed Care Organizations in those two years. I think that just from what I've experienced, the stuff that comes down from that is so anxiety provoking. The audits are ridiculous. It's very punitive and it almost feels like a sense of instability to a certain degree.

Participant 11 discussed the frustration and anger she feels at the mental health system as a threat to wellness. She noted "to be angry with the system, would be the way that outpatient in-home therapy works." Participant 4 stated "the politics that come along with just working in the setting, and not getting the support I need, or the supervision I need; I'm not satisfied." Participant 3 identified that the safety and location factors of client work can impact self-care and wellness. She stated "meeting clients where they are

means really putting yourself out there.” Participant 8 noted that one threat to her wellness is the role of assessor with clients. She reported:

I don’t get to see them through treatment. I don’t get to see them through the healing or I don’t get to see them through things looking better. I feel like I get to hear the heavy stuff and then maybe I can, you know, through collaboration with other clinicians or other agencies, get to hear the success stories on the back end. But, just doing assessments is really hard because of where they’re at right now. Where a family is at right now, knowing that I’m going to make a referral and I hope that they are going to get what they need.

Participant 10 identified that in spite of trying to incorporate self-care “somebody else’s crisis always seems to take precedence.” Finally, participant 9 noted that she felt generally disengaged in her work at times and identified that simply she doesn’t “do a good job of a lot of the traditional self-care means.”

Boundaries. Another way participants identified achieving or maintaining self-care is to create and maintain physical, relational, or cognitive boundaries. These boundaries seemed to span specific client related boundaries, administrative boundaries, and cognitive boundaries. Participant 1 reported that she will “try and be present in the moment and not over think things too much.” Participant 3 noted that location boundaries seemed helpful. She stated “I feel very fortunate to not work in the county where I live.” Participant 4 noted that she sets a cognitive boundary and reported, “I have to be mindful that I can only do what I can do and I can’t save everybody.” Participant 6 noted taking time when she returns home to do something for herself and indicated a reminder that she did not have to complete administrative components immediately. Participant 7 noted that she works toward a balance and seek support. Participant 8 reported that it is important

for her to create boundaries around taking client phone calls after hours. Participant 10 identified that his way of thinking about client issues had changed to a perspective of looking for solutions and that this created a cognitive boundary for himself. Participant 11 reported, “I’ve grown to be less rigid with my structure and my own time.”

Perspective. Participants also noted that working with clients had an impact on their personal perspective. This seemed to be a factor that they indicated as contributing to wellness. Participant 1 noted that when she thinks about things in her own life it is helpful to remember the experiences that clients encounter. She stated “it kind of puts things in perspective for me.” Participant 2 noted:

Personally seeing what people go through has really changed the way that I view the world. Actually in kind of a positive, like, I understand how really little things can be really amazingly wonderful for some people, and things that we take for granted every day that I don’t take for granted as much as I used to. There are lots of times that I forget, but then I’m with clients and see some of the things that can make some of my clients really, really happy, these are things that I think before I worked in this area, I wouldn’t have considered as a win.

Participant 6 indicated that her perspective had changed as well. She stated “it makes me grateful for my family and my support system and the kind of privileges that I’ve grown up with.” Participant 7 noted that her perspective of clients has changed in her work. She indicated:

I’m a big picture person. I love seeing the big picture. I love seeing where people are going to go with their lives and what they’re going to do. I just have to keep scaling it down to remind myself that this is their life and we are just a snippet of a part of it. There’s so much more that is going on. That the part I see is just so much smaller than what I may think it is.

Participant 11 noted that her perspective has changed as well noting that client work has made her more patient and flexible.

Cognitive appraisal. Similar to perspective and boundaries, participants began to identify ways that they think about the work they do. The team labeled this category cognitive appraisal to indicate the evaluative nature of participants' own thought processes that help to maintain wellness. Participant 1 noted that she remembers "it's not really about me. I try to let it be with the client." Participant 7 described a sort of appraisal that occurs with documentation and case management. She noted "case management gives me a time to debrief for myself." Participant 11 identified that she thinks more about the client's best interest when thinking about the work she does. In addition, participant 8 noted that she had at one time believed she was doing well with self-care and client work but a partner began to help her identify that she was displaying burnout behaviors.

Clinical Supervision

Participants were asked about their experiences with clinical supervision. Their responses included many factors including licensure related supervision along with administrative or organizational supervision.

Supportive relationship. The primary factor noted by all 11 participants was the presence of supportive characteristics of their supervisor. Participant 1 noted that her supervisor is "almost like a therapist for me sometimes." Participant 2 noted that she found her supervisor to be "really supportive and helpful." Participant 3 identified that her supervisor is supportive by "calling me to the carpet" or providing a reality check.

Participant 3 also described her supervisor by stating, “Supervision with her is awesome. I learn things. She teaches me things. She just helps me be a better counselor.” Participant 5 noted that her supervisor is supportive in having a person-centered approach. Participant 6 stated “I trust my supervisor and I think she is empathic enough that if I were having a problem, we could talk about it.” Participant 7 noted “I don’t think I would be at this level if I didn’t have my supervisor to call and to talk with and have such amazing support.” Participant 8 indicated “I have so much opportunity to talk about what is frustrating me and help me to reframe things with that supervision piece.” Participant 9 noted that her supervisor was supportive by the way they “held me to task.” Participant 10 noted that the collaborative nature of his supervisor was supportive. Participant 11 stated “I feel like I have someone to check things out with.”

Supervisor accessibility. Participants identified that working in CMH settings sometimes impacted their accessibility to their supervisor. Some participants described previous supervision whereas others discussed their current situations. It became a prominent theme for participants that having the ability to contact their supervisor and meet regularly were important. Nine of the 11 participants described accessibility as important. Participant 2 characterized a previously supervisor unfavorably and stated:

That person was just too busy and did not have enough time to actually devote to supervision. We had a lot of missed supervision session and I was starting to get kind of anxious that I wasn’t practicing within the scope of the law.

Similarly, participant 5 reported that her supervisor seemed too busy to make supervision a priority. She noted “I think sometimes that she may be supervising too many people, or maybe she just has too many other responsibilities as well.” Participant 4 indicated that although she has a supervisor that is providing for licensure supervision and meets regularly “supervision at my job is non-existent.” She indicated that this supervision was not adequate and she was therefore forced to seek additional support. Conversely, several participants identified that supervision was very accessible. Participant 6 indicated that her supervisor was on site with her and that she and her supervisor “check in pretty much every day and then we have an hour a week to sit down and go over things.” Participant 7 identified the consistency of supervision as ongoing for her. She stated “we have formal supervision with my main supervisor weekly but honestly I get supervised all the time. It’s never a moment where [sic] I don’t.” Similarly, participant 8 noted that she also has a lot of ongoing supervision support in both a formal and non-formal manner. Comparably, participant 9 reported that it was important to have a supervisor that was on site so that she had access to supervision and support. Participant 10 indicated that his supervision was mostly informal and this style offered more accessibility to supervision. He stated “I don’t like to put things on a shelf until a week later because if its something that is bugging me I like to get it dealt with.” Participant 11 also indicated that her supervisor was consistently available.

Clinical decision-making. Participants also discussed their satisfaction or need to have support with clinical issues related to client care that arise in their work. Five of the 11 participants described this factor in some way. Participant 1 identified that her

supervisor assists her with processing major client issues. Participant 2 stated that her supervisor helps with clinical decision-making by “breaking things down into how I could do things better and get to the goals that my client is going to need from me more efficiently.” Participant 3 described a specific time in which their supervisor supported her through clinical issues that surrounded client safety. Participant 7 said of her supervisor “getting those tips and hints for what’s worked with a client and what hasn’t worked from someone else, it’s just been life changing for me.” Participant 9 noted that her supervisor was helpful in talking through specific case needs as well.

Connect/disconnect to the community. When working in the CMH setting, many participants indicated that their supervisor was part of their employing organization. Other participants noted that their supervisor was not employed or associated with the same organization. For several of the participants this came up as a theme in their experiences of CMH. Participant 1 identified that she liked and appreciated her clinical supervisor but that her preference would be for her organizational director to be her supervisor if licensure requirements would allow. She stated,

I would want my director to be my supervisor. She knows the faculty of the schools that I am in and that is something [my licensure supervisor] does not have. Being community based, I think I would have a greater supervision experience if somebody in the community were my supervisor.

Similarly, participant 9 noted that her preference was to have an onsite supervisor based on a previous experience as compared to the current situation of having an external supervisor. Participant 9 stated:

They knew exactly what I was doing. It made for much more engaged supervision. In this one, this most recent one, was removed from that and she has her own opinions about my setting. Sometimes that wasn't always helpful. Yeah. I think it would have been a lot better if I had an internal supervisor who knew this kind of stuff I was dealing with and could tailor supervision for that context better than she was able to do.

Participant 6 described her experience with a supervisor whom she perceived as very connected to the same work. Participant 6 stated “she actually does the community mental health consultation stuff too so we are together on a lot of different things. We work well together.” Participant 7 indicated that her supervisor was incredibly connected to the work because the supervisor is part of upper management and had helped to form a lot of the teams that deliver the particular service model around the state. She noted “it’s been really helpful to have such a person who believes in what I do.” Participant 8 indicated that there was a benefit to having internal supervision. She stated:

We meet weekly just to make sure that we’re on the same page because there’s a lot with the role that I’m in. There’s a lot of communication that could be a breakdown and a lot of frustrations that I feel like if I’m open with her about she can fix them because she is my supervisor. Whereas my licensure supervisor doesn’t have any impact on my day-to-day job.

Financial burden. Supervision is a requirement of licensing boards and, when not included in a counselor’s employment, there are times that it can create a financial burden. All participants noted something regarding supervision as either a benefit or a burden. Only 2 of the 11 participants noted that they were responsible for paying for their supervision and did not consider it a burden to do so. Five of the 11 participants indicated that they received paid supervision either through their employer or through

reimbursement of their chosen supervisor. One participant who noted that their supervision was paid by their employer noted that they did not consider this a benefit since some limits applied to the amount that the organization was willing to pay and impacted the quality of the supervision they found. Four of the 11 participants indicated that paying for supervision was indeed a burden to them.

Participant 1 discussed paying for supervision as a burden but noted that she is willing to keep paying for it since she has had the same supervisor over the course of her clinical experience. Participant 1 noted “I’d rather be satisfied with my job than having supervision paid for [sic].” Participant 4 was very expressive regarding the financial burden of supervision. Specifically, participant 4 noted “as a provisional licensed person, it’s like I have to go broke before I can make money. Because I’m paying fifty dollars out. Basically two hundred dollars a month just for supervision.”

Participant 9 noted extensively that paying for supervision was a burden. She stated:

There were times when I thought I was going to have to figure out a way to quit supervision. I was going to have to take a hiatus with the board because I did not think I could pay for it. I was able to figure out a way, but it was really a question there at different points as to whether I could continue.

Participant 11 indicated some issues around financial burden and supervision. She noted that she is not reimbursed for clinical supervision with a supervisor that meets board requirements but is given supervision with an agency supervisor that is not approved by the board. Participant 11 noted:

Again, that was another thing I had to do that wasn't cost efficient for me. I would have to go to the agency to get supervision for an hour, which was free through the agency and discuss those cases. But, it was gas. It was time away from billable hours. Especially when I already had a supervisor that I was paying for, and that counted.

Participant 8 identified that supervision is paid for by the agency but that she had to go with someone she may not otherwise have chosen. She noted it is as a benefit provided by the organization but no real impact otherwise. Participant 2 indicated that she does pay for her own supervision at this time but thinks that the agency would reimburse or pay for assistance if she pressed the issue. She noted "it's honestly not that big of a deal for me for this very short time. If it were ongoing I would be going down and asking for help." Participant 3 noted that her organization did not pay for supervision but did not indicate that it was a burden. Participant 5 briefly disclosed that her supervision was free and advantageous but added no real discussion about it. Likewise, participant 6 only mentioned supervision briefly as a benefit for the job and provided no in depth discussion about the impact of this. Participant 7 also noted that supervision was part of the agency benefit with no expanded discussion. Similarly, participant 10 acknowledged that supervision was included as part of his job.

Encouraging self-care. Three participants expressed that having their supervisors encourage them in self-care was important. Participant 1 noted that supervision was like having a personal check-in that her supervisor made a point to "make sure I'm OK. Making sure I'm getting that work life balance down." In addition, participant 2 noted that her supervisor was, "encouraging me to do other things like take care of myself and spend time with my family." Participant 3 noted that her supervisor specifically

challenged her regarding the amount of indirect hours she was accruing to encourage self-care.

Mode of supervision. Three participants expressed some concern over the impact of the mode of supervision. Whereas it seemed most participants met directly in-person with their supervisor, several had experienced using Skype as a mode of supervision. Participant 1 noted that with the Skype experience she “[doesn’t] get that personal, face-to-face, in-person interaction which is good and bad.” She noted that although it could be convenient, it did not seem as personal. Participant 6 indicated that using Skype with her supervisor in the past made it feel impersonal as well. She noted “I never felt like he really knew me.” In addition, participant 8 reported that using Skype for supervision took a while to develop a personal sense of relationship.

Role conflict. Three participants noted that they had experienced some conflict with supervisors holding different roles. Participant 1 indicated that she had an issue with a client situation and noted “the agency supervisor was telling me to do one thing, and so you kind of had this power struggle. I was asking [my clinical supervisor] how to handle this.” Similarly, participant 6 reported a situation in which she had to navigate role conflict between supervisors. She stated “I called [my clinical supervisor] in crisis one time because I felt like we needed to hospitalize someone and my direct [agency] supervisor did not.” Comparably, participant 5 stated “I think having a supervisor who is also your employer, you can’t really be completely authentic and honest about what you’re experiencing.”

Modeling. Two participants discussed the importance of having a supervisor who models effective or appropriate behaviors as important. Participant 2 noted that her supervisor models self-care and work life balance. Participant 7 indicated that her supervisor modeled advocacy work with clients and that seemed important to the participant.

Supervisor identity. Two participants identified issues around supervisor identity. This factor was related to the professional identity of the supervisor or as the credential held. Participant 2 stated “interestingly enough I thought I would get more professional development support, professional identity kind of thing from a LPCS [Licensed Professional Counselor Supervisor]. That was actually the least helpful interaction that I had.” In contrast, participant 6 noted that in previous supervision experiences with a social worker and a psychologist, neither had understood her need for counselor identity.

Preparation

Participants were asked about what they believed may have prepared them for the work they are doing in CMH settings. Responses ranged from no preparation to various experiences in graduate school, internship, or other types of activities. A few participants indicated that nothing prepared them for their experiences in CMH but then went on to discuss how their internship experience was a factor in their preparation. The team also decided to separate internship from graduate school since the internship experiences were more specific to client contact or organizational work than academic training.

None. There was a reaction among four participants about their preparation that seemed to indicate they did not feel prepared before entering the field following graduate school. Participant 1 stated, “I had no idea. I didn’t know how to navigate this.” It seemed that this participant was referring more the administrative and billing components of the work of CMH rather than the clinical work. She did indicate that there was some lack of preparation related to case management. Participant 2 indicated that she was not “really prepared for what the work would actually look like.” This participant referred both to working with clients with psychosis and the administrative components. Participant 4 noted that she also did not feel prepared. She stated “In graduate school, I can tell you, they painted a pretty picture and they didn’t really give me the reality of the situation.” Similarly, participant 5 stated that she did not feel prepared for CMH work. She stated “the graduate school did not prepare us for this at all. They gave great skills, but not for this.” Participant 5 referred to the specific needs within CMH settings.

Graduate school. Three of the 11 participants noted that graduate school was an important component of their preparation. Participant 6 reported that her graduate program was a definite positive factor for her. Participant 7 indicated that much of the specific knowledge gained related to diagnosis was helpful in preparing her for CMH. Participant 8 noted that her graduate program was most helpful in preparing her because there was an emphasis on self-care as well as the opportunity to take expressive arts courses that contributed to self-care.

Internship. Five of the 11 participants identified that their internship experiences were important to their preparation. Participant 2 noted that in her internship she received

support and validation that contributed to a sense of preparedness for the CMH setting. Participant 3 identified that the internship experience helped her to figure out what components she liked or preferred in CMH work. She noted that the experience of doing the work in the internship was very helpful. Similarly, participant 5 indicated that the internship was helpful for gaining insight into what to expect in the CMH setting. She stated “I think an internship at community mental health agencies would be beneficial to know exactly what you’re getting into.” Participant 6 reported feeling very prepared by the internship experience. She indicated:

I felt very prepared and in my internship too. Having seen those more extreme behavioral issues and really having kind of eye-opening experiences of how bad things can get for families and the challenges they face. I had a supportive environment where I had group supervision and individual supervision. I wasn’t on my own. I think seeing that and all the experiences in graduate school really prepared me.

Similarly, participant 7 indicated that internship was preparatory by giving the participant the opportunity to see what she was working with as a long-term process.

Counselor Factors

Participants identified various factors about themselves that seemed to impact their personal experiences within the setting of CMH. Whereas they were not specifically asked about their own personal experiences, themes began to rise and the team noted these seemed significant. The predominant aspects that surfaced related to what could best be described as personality traits of the individual participant. In addition, traits and beliefs such as sense of self-efficacy, maturation, and values and ethics were identified.

Personality traits. Participant 1 noted that she enjoys variety in her work and lives. Participant 2 identified enjoying working with a population that is generally considered difficult. She attributed this to being good at it and noted that she was aware that others were not always good at it. This seemed to be partly due to her personality. Participant 9 reported that she “feels like I’m really good at just making people comfortable.” This was not attributed to skills, rather seemed to be a part of the counselor’s personality. Participant 10 stated that he does well in situations in which he is alone. He stated “I’ve always been the kind of person that’s alone. I’m not an outgoing person so that probably helps with [the stress of the CMH work].” Participant 11 identified that she see herself as a compassionate person.

Self-efficacy and maturation as a counselor. Participant 4 reported that one of the factors that supported her in CMH work was simply doing the work. This could be considered maturation. She stated “Just doing it. Doing the experience everyday and learning.” Conversely, participant 5 reported that a potential hindrance to self-efficacy and maturation came from negative experiences. She stated “when you feel [like you’re drowning] professionally, that can lead to personal concerns with self-esteem, my own feeling of depression or anxiety and things like that.” Participant 9 noted that she experienced maturation and reported, “I had a harder time with boundaries than I do now.” Participant 11 identified maturity and self-efficacy with experience as well. She reported “I was really afraid [of working with children] at first. But you learn. You learn as you go along.”

Values and ethics. Three participants seemed to identify that values or ethics had a role in their experiences of CMH. Participant 3 reported that it is important for her to be “authentic and genuine.” Participant 7 noted that using person-centered theory was important because it aligned with her values and view of how to help people. Participant 11 indicated that advocacy was important and related to her values and sense of ethics in her work with clients.

Summary

This chapter included a review of the data collected and the qualitative analysis performed by the CQR team. In conclusion, participants in this study identified multiple factors that impacted their experiences of working in the CMH setting. The research team reviewed data presented by participants and developed eight domains. These domains included categories that were labeled general, typical, and variant. Of the 42 categories, 3 were labeled general, 20 were labeled typical, and 19 were labeled variant. A discussion of the results and related research questions will be presented in Chapter 5.

CHAPTER V

DISCUSSION

In Chapter IV results from the qualitative study exploring the experiences of entry-level counselors in CMH settings were reported. In this chapter an overview of the study is provided, the results of the study are discussed, and limitations of the study are addressed. Implications for counselors and counselor educators and areas of potential future research are explored.

Overview of the Study

It is well known that professional counselors may experience physical and emotional symptoms that may ultimately affect their quality of work (Figley, 1995; Figley, 2002; Maslach, 2003). Deficits in wellness of counselors can have significant consequences in the ethical care of clients (ACA, 2005; 2014; Kocet, 2006; Neumann & Gamble, 1995; Pearlman & Saakvitne, 1995). Specifically, entry-level professional counselors in community mental health (CMH) settings may be at a higher risk of experiencing these deficits to wellness compared to their more experienced counterparts (Farber, 1985; Lawson & Myers, 2011; Lent & Schwartz, 2012; Pearlman & MacIlan, 1995; Sprang, Clark & Whitt-Woosley, 2007). In addition, entry-level counselors may not have the skills or support to maintain their wellness and thus protect them from impairment stemming from organizational variables within the CMH setting (Lawson, 2007; Farber, 1985; Pearlman & MacIlan, 1995; Sprang et al., 2007). As such, the

challenging clientele, organizational factors, and supervision experiences in CMH settings may have unique influences on entry-level professional counselors' experiences with wellness. Unfortunately, a common trend in CMH agencies is that the least experienced counselors work with the most severe of client needs (Pearlman & MacIain, 1995; Wachter Morris & Barrio Minton, 2012).

Researchers have examined elements of wellness among counseling students (Lambie, Smith, & Ieva, 2009; Myers, Mobley & Booth, 2003; Perepiczka & Balkin, 2010; Roach & Young, 2007), counselor educators (Wester, Trepal, & Myers, 2009) and professional counselors (Lawson, 2007; Lawson & Myers, 2011; Lent & Schwartz, 2012; Mobley, 2004; Randolph, 2010). However, greater emphasis on wellness and prevention of impairment as well as calls in the literature for managing impairment factors within the field of counseling (Lawson & Venart, 2005; Sheffield, 1998; Witmer & Young, 1996) has spurred limited empirical investigation related to the experiences of entry-level professional counselors (Freadling & Foss-Kelly, 2014). Furthermore, the work environment of entry-level professional counselors and how this impacts their experiences of wellness, has been largely neglected (Borders & Hamilton Usher, 1992; Fall & Sutton, 2003). As such, continuing to overlook the needs of entry-level professional counselors poses not only a risk to counselor wellness but also to client welfare (Lawson & Venart, 2005).

The purpose of this study was to investigate the experiences of entry-level professional counselors working within CMH agencies and how these experiences impact their professional quality of life and wellness. In particular, the experiences of entry-level

professional counselors were explored within the context of the clientele they typically serve, the organizational factors they face on a daily basis, and the supervision they receive as entry-level counselors.

Discussion of the Results

Research Questions

Research questions for this study were developed to investigate experiences of entry-level counselors in community mental health. Research questions were based on existing literature and created to explore potential impacts to counselor wellness.

1. What are the overall experiences of entry-level professional counselors working within community mental health settings and their impacts to professional quality of life and wellness?
2. How do entry-level professional counselors working in community mental health settings perceive the impact of client factors on their professional quality of life and wellness?
3. How do entry-level professional counselors working in community mental health settings perceive the impact of organizational factors on their professional quality of life and wellness?
4. How do entry-level professional counselors working in community mental health settings perceive the impact of personal factors on their professional quality of life and wellness?
5. How do entry-level professional counselors experience developmental critical incidents within the setting of CMH?

Research Question 1

Participants were asked questions that pointed to specific components of their experiences in the CMH setting. However, because there is such limited research with this population, many of the questions were developed to explore the participants' experiences in general. To this end, some basic questions were asked in the interviews, which contributed to both introducing the study as well as gaining an overall sense of what entry-level counselors experienced in CMH settings. The first two interview questions included opportunities for participants to disclose their job title or role in the CMH setting as well as to explore their experiences with the ProQOL measurement. Participants noted many different titles used in their various organizations. The most common title used was *therapist*. In addition, some participants reported that their title correlated with their role such as *assessor* or *intensive in-home lead*. Only one participant identified that their title included the word *counselor*.

To further explore the experiences of entry-level professional counselors the ProQOL was administered prior to interviews. All participants completed the scale. Seven of the participants reported that the experience of taking the measure created a sense of reflection about their work in the counseling field. Four participants identified that the measurement brought a sense of awareness to their personal functioning in the field. Whereas none of the participants identified burnout or secondary traumatic stress on the measurement, all participants expressed an awareness of these terms and discussed their experiences accordingly.

Six of the participants noted that they believed their scores might have been different if they had taken the measurement at a different time. Most noted a previous job where they felt less well or experienced what they considered a greater sense of burnout. This reaction of the participants to seek a different job or setting points to the positive message of the counseling field to monitor for signs of impairment and seek support or limit client care until remediated (ACA, 2014). Providing the participants with a measurement such as the ProQOL seemed to initiate a discussion of their experiences in the CMH setting. For example, participant 6 stated:

I worked for six months before coming here doing intensive in-home work and that just about killed me. My personal wellness and self care has dramatically improved since leaving that job so it's nice for me to kind of reflect on how far I've come and just kind of knowing what it's like to feel burnt out, but now, kind of feeling more balanced and having more flexibility in my schedule and my time.

Participants discussed many experiences that related to the CMH setting. Most of the typical responses from participants included experiences such as having limitations on their choice of job or setting due to licensure and experience deficits. In addition, participants most typically expressed experiences related to the administrative burden, accountability practices, and rigidity they face within their organizational experience. Participant 11 provided an example of many of the administrative experiences she observed. She stated:

We've had a lot of new paperwork here at this current agency this year that we didn't have to do last year and things were being updated every few months it seemed like, at one point. I'm not sure why. I'm not sure if that came from [the Managed Care Organization] or the powers that be or whomever, but we had a lot of extra paperwork that had to be done. For each client, we had a packet, like

really thick, like this thick, for each client that needed to be done. I know it's necessary but it does take time away from the counseling.

Further, respondents generally noted that they work with very complex client issues. This was a universal response from all participants and indicated that entry-level counselors experience significant challenges with their caseloads.

Another common experience noted by participants is that of seeking strategies to manage self-care. All participants identified some way in which they work to deal more effectively with stressors in their lives. Whereas this is a positive experience expressed by the participants, it also appeared that nearly all of the participants expressed things from their work that posed a threat to their wellness. Much of the threat seemed to stem from the administrative burden and accountability practices that are required of them within the CMH setting. For instance, participant 2 noted that she “would be doing paperwork until two or three in the morning and then getting up to see clients.”

Supervision is a near universal experience for entry-level professional counselors and is a requirement in all states for those seeking licensure (Bergman, 2013). The most general experience reported by participants within supervision was the need for support in the supervision relationship. Accessibility to the supervisor was another important need noted by participants. However, many of the respondents struggled with this accessibility and had at times felt they had less support and accessibility to their supervisor than needed. These general experiences of entry-level counselors are explored in greater detail below.

Research Question 2

One of the most frequently cited responses from participants regarding organizational factors was that of administrative burden. All participants identified that paperwork is an expectation of their work and 80% of participants noted that they perceived this to be a burden on them. This administrative piece of work within the CMH setting stemmed primarily from the accountability practices enforced by funding sources such as Medicaid as well as various compliance requirements required of organizations. Participants expressed concerns that their requirements for completion of paperwork did impact their ability at times to focus on client care. One positive factor expressed by most participants was that of administrative support. The most common term used for this support within organizations is *utilization review*. Participants noted that this was supportive to them related to the billing component of service delivery. Although participants were clear in reporting that they were responsible for specific formatting of the information, there was a person or supportive department that assisted with billing and followed through with the business component of their work.

Participants identified organizational rigidity as a concern in their experiences. Some participants identified that their organization mandated certain types of models for service delivery. Most of the rigidity was related to time expectations or specific formats for submitting paperwork. For instance, many participants identified having to submit paperwork within 24 hours of service delivery. Participant 5 identified that there is added pressure with paperwork and stated, "...they have these punitive measures in place where your pay will significantly drop if you don't get it in on time."

Although safety concerns were not major factors reported by participants, several did identify that they had concerns with safety when delivering services in the context of the community. Participant 6 expressed having directed these concerns to the organization with little support or reaction. She stated, "...I didn't really feel safe on the job, and I had expressed concerns about safety but I didn't get a lot of support."

It became clear in this study that participants experienced significant organizational impacts primarily related to administrative requirements rather than clients needs. Support emerged primarily as utilization review or administrative roles, which offered assistance with billing features. In addition to administrative burden and varied forms of support, participants identified that client concerns and needs impacted their sense of wellness and professional quality of life.

Research Question 3

Participants identified many complexities that they are confronted with in their caseloads. Surprisingly, diagnosis was not the primary factor that participants cited. Rather, they identified that many of the complexities involved family disruption or other social factors faced by clients are the most impactful in their work with clients. Many participants noted that clients' limited access to resources had a major impact on their work with clients. For example participant 7 stated:

It's really hard sometimes especially with a lot of my homeless clients. It's so hard to just drop them off at the end of the hour session. It's like well; you've talked about all your problems. Well, now you're back into it.

In addition, a typical response from participants regarding client issues was that of acuity or crisis management. Five of the 11 participants identified some level of acuity in their client caseloads. This included suicidal behaviors, self-injury, and regular crisis intervention. A few participants identified factors, such as mandated counseling services, which impacted the counselor's ability to develop rapport and trust.

Research Question 4

Personal factors for counselors may include self-care, training and experience, along with personality traits. Respondents in this study most generally discussed their perceptions of self-care. All 11 participants identified that they work toward self-care by utilizing various strategies. These strategies included physical exercise, hobbies, spiritual practices, or other types of activities. In spite of this seemingly positive reaction of the participants, 80% of participants also identified threats to their wellness. These issues included paperwork demands, organizational factors, and client demands.

In addition, participants identified a typical reaction to wellness threats as creating boundaries. Participants noted boundaries with clients, boundaries with administrative duties, and cognitive boundaries. For example, participant 1 noted, "I try and be present in the moment and not over think things too much." Participant 4 identified that they place a cognitive boundary around client issues and noted, "I have to be mindful that I can only do what I can do and I can't save everybody." To address administrative boundaries, participant 6 reported it is important to "take time to myself when I get home. I don't have to do notes right away."

Preparation of participants also emerged as a personal factor impacting experiences within CMH settings. Four participants identified that they felt nothing had prepared them for CMH work. However, a more typical response from participants indicated that their experiences of internship seemed to most directly prepare them for working in CMH settings. This desire for hands-on exposure within CMH was supported by responses that centered around seeing specific diagnoses, having validation of their work, and simply getting to experience the work. Furthermore, most participants identified that even if they felt somewhat prepared for their work, they did not feel prepared for the administrative components or expectations.

The counselor as self and its impact on counselor wellness was another factor examined in this study. To this end, self-reported personality traits did emerge as a typical factor impacting their choice of career and the way in which they experienced CMH settings. Many participants identified something about themselves that seemed to contribute to their experiences. For instance, participant 1 noted that she “enjoy[s] variety.” Participant 11 described herself as “a compassionate person.”

Research Question 5

Participants in this study focused primarily on their supervision experiences rather than describing various critical incidents that they experienced. All participants identified that it was important for them to have a supportive relationship with their supervisor. Further, 80% of participants reported that they desired accessibility to their supervisor. Multiple respondents noted that they felt their supervisor seemed too busy or had multiple responsibilities that were a hindrance to accessibility. However, most

respondents noted that their supervisor was available to them and had regularly scheduled supervision. One theme that emerged related to supervisor accessibility was the supervisor's connection to the community or population with whom the counselor was working. Some participants reported that their supervisor was employed by their organization and some identified that their supervisor was an outside provider. The participants in this study indicated that having a supervisor who understood the context of CMH was valuable. Surprisingly, participants did not discuss evaluation and employment duties of their supervisor as a conflict. It appeared that as long as the supervisor presented as supportive and connected, there was little concern over the ability of the supervisor to make employment decisions. The primary conflict emerged as related to a supervisor who was more involved in administrative duties or other organizational responsibilities than a supervisor who had administrative power over the participant. This is promising considering that many entry-level professional counselors may not have access to resources for supervision outside of the agency. Conversely, 45% of respondents indicated that supervision has been a financial burden for them at some point. In one extreme case, participant 9 stated that she had considered leaving the field at least temporarily due to the financial strain of low wages and high cost of supervision.

Discussion of Domains and Categories

Within the framework of the research questions, this study generated eight domains overall. Each domain was further analyzed and multiple categories emerged. For this study, a label of *general* was used when the category was marked in 10-11 cases. The label of *typical* was assigned for categories marked in 5-9 cases, and *variant* was

assigned for categories marked in 2-4 cases. Of the 42 categories, 3 were labeled general, 20 were labeled typical, and 19 were labeled variant. The research team identified eight domains through the process of transcript review and consensus meetings. The domains are identified as: (a) job title or role, (b) ProQOL experience, (c) career choice, (d) organizational factors, (e) client factors, (f) self-care or wellness, (g) preparation, and (h) supervision. Each of the domains along with related core ideas and categories will be described and discussed below.

Job Title or Role

The domain of job title or role primarily provided the CQR team with descriptive data. Participants noted many different titles used in their various organizations. The most common title used was *therapist*. In addition, some participants reported that their title correlated with their role such as *assessor* or *intensive in-home lead*. Only one participant identified that their title included the word *counselor*.

These various titles are simply listed here with no repetition as follows: (a) Outpatient Therapist, (b) Community Support Team, (c) Community Based Counselor, (d) Therapist, (e) Intensive In-home Team Lead, (f) Early Childhood Mental Health Consultant, (g) Vocational Specialist, (h) Clinical Assessor, (i) Licensed Professional Counselor Associate. No previous research or literature was found that seemed to illuminate any particular impact on counselor wellness or professional quality of life. However, these are provided here because the title of a counselor may indeed be an important part of a counselor's experience and identity. It also shows the variations of titles and roles that entry-level counselors are taking on following graduate school

ProQOL Experience

To further explore the experiences of entry-level professional counselors the ProQOL was administered prior to interviews. This was primarily done to capture descriptive data rather than specific impairment or wellness information. Having the ProQOL scores of the participants helped to ensure that the sample was more homogeneous and that no significantly impaired counselors participated in the study. All participants completed the scale. None of the participants identified negative scores indicating burnout or secondary traumatic stress on the measurement. During the interviews all participants expressed an awareness of these terms and discussed their experiences accordingly. The ProQOL was included in the interview as a starting point for discussion and only elicited participant reactions related to the experience of taking the ProQOL.

Whereas respondents in this study scored low on burnout and secondary traumatic stress, they generally scored average for the compassion satisfaction subscale. This indicated that participants were not as satisfied as they could be in their work. Seven of the participants reported that the experience of taking the measure created a sense of reflection about their work in the counseling field. Four participants identified that the measurement brought a sense of awareness to their personal functioning in the field. Six of the participants noted that they believed their scores might have been different if they had taken the measurement at a different time. Most noted a previous job where they felt less well or experienced what they considered a greater sense of burnout.

Career Choice

Participants were asked to describe factors that impacted their decision to work in the setting of CMH. Most of the typical responses from participants included experiences such as having limitations on their choice of job or setting due to licensure and experience deficits. Although there is limited research that reports what counselors do beyond graduation, this seemed to reflect consistency in the existing literature that new counseling graduates may seek employment in CMH settings due to inability to find jobs elsewhere (Freadling & Foss-Kelly, 2014; Randolph, 2010). Howard et al. (2006) suggested that this limitation due to licensure could contribute to feelings of confusion or uncertainty regarding a counselor's career choice. Indeed, this study did confirm that entry-level counselors are limited to the types of jobs available to them.

Further, this seemed to create feelings of confusion from the participants when discussing how they felt their graduate school experience had prepared them for work in CMH settings. Skovholt and Ronnestad (2003) suggested that questions related to career choice could be a response to glamorized expectations from early stages of training. In spite of the limited choices for entry-level counselors, the participants confirmed that it is important to them to associate positive values with the work they do. It is the need to associate values to one's work that truly encompasses professional quality of life. Compassion satisfaction has been identified as significant in the overall well being of counselors (Figley, 2002). It appears that entry-level counselors in CMH settings face limitations in their choices of how they deliver services to clients but also seek value in their work that contributes to their sense of meaning.

Organizational Factors

A review of the existing literature pointed to multiple experiences within CMH settings that may impact entry-level counselors' experiences. These included such things as managed care issues, funding restraints, limited recourses and significant paperwork (Acker, 2010; Isett et al., 2009). Indeed, the results of this study generated similar reports from participants. One of the most frequently cited responses from participants regarding organizational factors was that of administrative burden. All participants identified that paperwork is an expectation of their work and 80% of participants noted that they perceived this to be a burden on them. This administrative piece of work within the CMH setting stems primarily from the accountability practices enforced by funding sources such as Medicaid as well as various compliance requirements required of organizations.

Participants expressed concerns that their requirements for completion of paperwork did impact their ability at times to focus on client care. This is consistent with previous research that emphasized that compliance and administrative regulations may take away a focus on client care (Lent and Schwartz, 2012). One positive factor expressed by most participants was that of administrative support. The most common term used for this support within organizations is *utilization review*. Participants noted that this was supportive to them related to the billing component of service delivery.

Although participants were clear in reporting that they were responsible for specific formatting of the information, there was a person or supportive department that assisted with billing and followed through with the business component of their work. Whereas this was a positive and supportive experience noted by participants, this need

for utilization review does point to the changes within CMH settings that reflects the need for organizations to consider how profitable they are as well as to report the organization's ability to provide efficient care rather than primarily focus on providing quality care to clients (Acker, 2010; Bolen & Hall, 2007).

Participants typically expressed experiences related to the administrative burden, accountability practices, and rigidity they faced within their organization experience. This is consistent with the literature indicating that administrative burden is an overloading factor impacting counselors in a negative manner (Freadling & Foss-Kelly, 2014; Isett, et al., 2009; Lent & Schwartz, 2012). This study also confirmed previous research that indicated counselors in MCH settings are being asked to utilize specific treatment modalities (Isett, et al., 2009; Lawson, 2005). Participants expressed that these modalities and expectations create rigidity in their experiences of service delivery to clients. Researchers have suggested that this rigidity can contribute to a lack of autonomy and subverts a sense of freedom in their professional practice (Isett, et al., 2009; Lawson, 2005).

Limited research has been completed that addresses other organizational factors identified by participants, such as salary. Participants identified that they struggled with serving clients due to significant administrative burden and securing funding for clients. This was noted at times to impact their own wages or salary. Several participants noted that they are not paid unless they provide direct service to clients. This meant that those participants were not compensated for preparation time prior to providing services or for any follow up necessary related to documentation or administrative tasks. This was

confirmed in a recent similar study, which indicated that entry-level counselors in CMH are only being paid for their time spent directly with clients (Freadling & Foss-Kelly, 2014).

Client Properties

Participants identified many complexities that they are confronted with in their caseloads. Interestingly, diagnosis was *not* the primary factor that participants cited as creating complexity in their work. Rather, they identified that many of the complexities involved family disruption or other social factors faced by clients, and these are the most impactful in their work with clients. Many participants noted that clients' limited access to resources had a major impact on their work with clients. In addition, a typical response from participants regarding client issues was related to acuity or crisis management. Five of the 11 participants identified some level of acuity in their client caseloads. Researchers have noted that more complex and high-risk clients have been associated with counselor distress (Acker, 2004; Lawson & Myers, 2011; Isett, et al., 2009; Walsh & Walsh, 2002). Whereas this is a common experience for counselors in CMH settings, it may be that newer, less experienced counselors have limited exposure and training to effectively manage these situations as well as their own personal reactions (Barrio Minton & Pease-Carter, 2011; Gibson, Dollarhide, & Moss, 2010; Wachter Morris & Barrio Minton, 2012).

Self-care/Wellness

All participants in this study identified some way in which they strive to deal more effectively with stressors in their lives. In spite of this seemingly positive reaction

of the participants, 80% of participants in this study also identified threats to their wellness. Much of the threat stemmed from the administrative burden and accountability practices that are required of them within the CMH setting. This too, is consistent with previous research about the impact of administrative components on counselor wellness (Freadling & Foss-Kelly, 2014; Stamm, 1997). All 11 participants identified that they work toward self-care by utilizing various strategies. These strategies included physical exercise, hobbies, spiritual practices, or other types of activities. It seems that the awareness of wellness and self-care among participants reflects the paradigm of the importance of wellness within the counseling field (Myers, 1991; Myers, 1992; Myers & Sweeney, 2008). Researchers have suggested that counselors are intentional about utilizing activities to maintain wellness (Cummins, Massey, & Jones, 2007; Myer & Ponton, 2006; Young & Lambie, 2007). These issues ranged from paperwork demands and organizational factors to client demands.

In addition, participants identified a typical reaction to wellness threats as creating boundaries. Participants noted boundaries with clients, boundaries with administrative duties, and cognitive boundaries, a finding consistent with Freadling and Foss-Kelly (2014) in which the researchers found that entry-level professional counselors in CMH settings valued creating various types of boundaries. Furthermore, the current study confirmed what previous researchers suggested regarding self-care for counselors. Lawson and Myers (2011) included a survey of career-sustaining behaviors in their study examining counselor wellness. They identified multiple components of the Indivisible Self Model of Wellness (IS-Wel; Myers & Sweeney, 2005) as specifically related to the

Creative Self. The Creative Self contains (a) Thinking, (b) Emotions, (c) Control, (d) Work, and (e) Positive humor (Myers & Sweeney, 2005). Lawson and Myers (2011) identified that counselors engaged humor, awareness of emotions, a sense of control, reflecting, and balance of work and personal life as top career-sustaining behaviors. Whereas this current study did not assess career-sustaining behaviors directly or administer a wellness measurement, participants did identify attempts to balance their work and personal lives, use of thought processes that included awareness of their emotions and experiences, as well as a sense of perspective on their client's experiences related to their own personal experiences.

Clinical Supervision

Supervision of counselors is perhaps the most central theory of effectively facilitating counselor development (Borders & Brown, 2005; Borders & Usher, 1992; Loganbill et al., 1982; Worthington, 1987). In addition, supervision is a general requirement for licensure (Bergman, 2013). Critical incidents have been identified as significant moments of learning that propel counselors toward new growth and expertise (Heppner & Roehlke, 1984; Howard et al., 2006; Morrisette, 1996; Skovholt & McCarthy, 1998) and primarily are thought to be best framed through supervision (Howard et al., 2006). The previous literature has focused only on critical incidents and supervision for counselors-in-training (CITs) rather than on professional counselors.

Further, 80% of participants in this study reported that they desired accessibility to their supervisor. Multiple respondents noted that they felt their supervisor seemed too busy or had multiple responsibilities that were a hindrance to accessibility. However,

most respondents noted that their supervisor was available to them and had regularly scheduled supervision. One theme that emerged related to supervisor accessibility was the supervisor's connection to the community or population with whom the counselor was working. Some participants reported that their supervisor was employed by their organization and some identified that their supervisor was an outside provider.

Previous writers have suggested that it is best to separate clinical supervision with administrative roles in supervision (Association for Counselor Education and Supervision; ACES, 1993, 2011; Falvey, 1987; Henderson, 2009; Kaiser, 1997). Results of this study point to a difference in experiences of entry-level counselors and the general assumptions of the counseling field. The participants in this study indicated that having a supervisor who understood the context of CMH was valuable. Surprisingly, participants did not discuss evaluation and employment duties of their supervisor as a conflict. It appeared that as long as the supervisor presented as supportive and connected, there was little concern over the ability of the supervisor to make employment decisions.

Rather, the primary conflict emerged as related to a supervisor who was more involved in administrative duties or other organizational responsibilities than a supervisor who had administrative power over the participant. Participants seemed to prefer the on site supervision experience as long as the supervisor was supportive and available to them. This is promising considering that many entry-level professional counselors may not have access to resources for supervision outside of the agency. Indeed, 45% of respondents in the current study did indicate that supervision has been a financial burden

for them at some point For instance; participant 4 noted that she pays at least two hundred dollars per month for her supervision.

Researchers have suggested that supervision is an effective way for counselors to manage stressors (Adams & Riggs, 2008; Bell et al., 2003; Newell & McNeil, 2010; Pearlman & Saakvitne, 1995; Sommer, 2008; Sommer & Cox, 2005; Trippany, et al., 2004). This was supported by responses in the current study. Participants did indicate that supportive supervision and the encouragement of self-care were important. More research indicating how this specifically occurs may be warranted to further support the claims that supervision is effective for entry-level practicing counselors in CMH settings.

Preparation

Preparation of participants also emerged as a personal factor impacting experiences within CMH settings. A few respondents identified that they felt nothing had prepared them for CMH work. However, a more typical response from participants indicated that their experiences of internship seemed to most directly prepare them for working in CMH settings. This desire for hands-on exposure within CMH was supported by responses that centered around seeing specific diagnoses, having validation of their work, and simply getting to experience the work. This is consistent with previous research in which participants identified that experiential learning was significantly valued (Freadling & Foss-Kelly, 2014). Furthermore, most participants identified that even if they felt somewhat prepared for their work, they did not feel prepared for the administrative components or expectations. Previous researchers have noted that these

unique organizational challenges do not tend to be covered in traditional graduate training programs (Skovholt & Rønnestad, 2003).

Counselor Factors

Counselor as self was a final component examined in this study. To this end, self-reported personality traits did emerge as a typical factor that impacted participants' experiences of CMH settings. Many participants identified something about themselves that seemed to contribute to their experiences. For instance, participant 1 noted that they "enjoy variety." Participant 11 described themselves as "a compassionate person." Themes of self-efficacy and maturation emerged to a lesser extent. This is somewhat surprising considering that previous researchers tended to link counselor wellness with other personal factors such as professional identity and competency (Gibson, Dollarhide, & Moss, 2010; Gibson, Dooley, Kelchner, Moss, & Vacchio, 2012).

Limitations of the Study

This study was an attempt to give a voice to entry-level counselors working in CMH settings. Although many attempts were made at providing the most rigorous research methodology, limitations of the study should be considered. Primary limitations were related to the sample and other limitations were relevant to the methodology of CQR. Participants for this study were recruited purposively due to the inclusion criteria and the desire to explore experiences in a very specific context.

The sample lacked diversity in terms of gender, as 10 of the 11 participants were female and 8 of the 11 participants identified as Black or African-American.

Furthermore, each participant was employed by a different organization with variance of

expectations within those organizations. In addition, whereas participants all reported that they attended a CACREP counselor education program within the state of North Carolina, they were not required to report the specific institution. The study did not account for detailed differences in training and relied on the assumption that CACREP standards would support homogeneity. In addition, the sample was only drawn from North Carolina based counselors and, therefore, participants only recounted their experiences related to the North Carolina mental health system. This limits the ability to generalize to other state requirements. In addition, differences between nonprofit and for profit organizations was not discussed, leaving unknown the possibility that additional factors of influence were present in organizational impact.

One limitation regarding the methodology is that the principal researcher has had significant experiences with the context of CMH settings and supervision of entry-level counselors. CQR was chosen as the preferred method in order to enhance the rigor of the study and to keep the principal researcher from communicating biases in the questioning and analysis of the data. Self-report was used as the primary means of accounting for participant experiences via interviews. Participants were also provided interview protocol prior to the meeting. It is possible that self-report and the ability to prepare for the interviews may have led to biased reactions or that social desirability impacted the participants' responses.

Although the limitations of this study must be considered, many strategies and attempts to reduce errors in protocol and bias were used. The CQR team consisted of a diverse group of individuals who provided significant questioning and examination of the

research process. A pilot study and external review of protocol, including research questions, interview questions, and methods of participants selection, were conducted.

Implications for Counseling and Counselor Education and Supervision

The results of this study provide implications for many facets of the counseling field. Participants shared experiences related to preparation for the work, administrative components of their work, and ways in which they attempt to navigate these unique challenges. This research can be applied to the specific population of entry-level counselors within the CMH context. In addition, suggestions can be made for counselor educators, counselor supervisors, and CMH organizations.

Participants in this study indicated that their most common experiences related to attempts at self-care, supportive supervision, and excessive administrative burden. In spite of any organizational factors or preparation limitations, self-care is ultimately the responsibility of each individual counselor (ACA, 2014; Venart, Vassos, & Pitcher-Heft, 2007). Therefore, it is significant for entry-level counselors to become aware of their own needs for managing the impacts of their work on their wellness and professional quality of life. This self-care will likely need to focus on managing their time and administrative duties in the context of client care. Furthermore, entry-level counselors will be best served if they learn more about expectations for supervision within the context of CMH and learn specifically to be more vocal regarding their needs for support and accessibility. Considering that entry-level counselors do not always have the needed level of competency or self-awareness that facilitates more assertive requests for support, it falls to counselor educators and supervisors to equip new counselors for wellness.

Participants identified several factors from their experiences of preparation for CMH work as central. Counselor educators may best support and prepare counseling students for work in CMH settings by first maintaining transparency regarding the potential work environments available to their graduates. In addition, counselor educators should consider licensure requirements and prepare students for those expectations. Understanding the local and regional needs of the mental health system in the area of the institution could be helpful to both educators and students. This could offer more information and in turn, offer the ability to teach or at least include discussions in the context of courses or supervision. Assisting counseling students in understanding how to navigate the mental health system or to know where to find this relative information, seems straightforward and helpful to begin to prepare entry-level counselors for the CMH setting. Considering that counselor educators are under their own sense of pressure to meet standards and to incorporate many facets of counseling experiences during graduate training, requiring extra courses may not be feasible. However, many participants identified that the administrative components of their work in CMH settings were the very experiences for which they were least prepared. Inclusion of a case management course has been suggested in previous research (Freadling & Foss-Kelly, 2014) and appears to be something worth considering. Case management and administrative components will likely be specific to state or organizational needs; however, understanding basic treatment planning strategies and learning how to locate resources for clients would develop skills that follow the counselor throughout their career.

Finally, it seems that with the lack of research that addresses recent graduates or entry-level counselors in any setting, it may serve counselor education programs well to track their graduates' experiences in some way. This could involve a yearly survey that asks questions related to their work location, various duties, and levels of satisfaction with their preparation for what they face. Some of this information may already be collected for CACREP (2015) reporting and would simply need to be more specifically directed to retrieve information about CMH experiences.

Supervision has been noted as part of the strategy in the counseling field to support counselors in providing ethical client care as well as for developmental growth (Bober & Regehr; Cummins, Massey, & Jones, 2007; Etherington, 2009; Myer & Ponton, 2006; Young & Lambie, 2007). Participants in this study indicated clearly that they desired to have supportive relationships with their supervisors as well as accessibility to them. Supervisors providing support to entry-level counselors in CMH settings may benefit from becoming aware of the unique needs of these counselors. Ensuring accessibility, connection, and understanding of the specific duties of the counselor were reported by participants as significant.

According to developmental models of supervision, counselors at this level of experience have been thought to experience some confusion and to some extent a need to vacillate between dependence and autonomy (Borders & Brown, 2005; Loganibill et al., 1982; Skovholt & Ronnestad, 1992). Supervisors should consider this when addressing issues in the CMH context with entry-level counselors. An active role in assisting entry-level counselors in self-awareness and in the new tasks and challenges they face in the

CMH setting should be prioritized by the conscientious supervisor (Borders & Brown, 2005). Understanding that counselor education programs and licensure boards rely on supervisors to extend learning and gatekeeping, it may become necessary for supervisors to seek training and support related to aspects such as client access to resources and administrative requirements. If a supervisor is not on site with the counselor, it could be valuable to conduct site visits to ensure that a supervisee feels supported and that the supervisor is not disconnected. Further, supervisors should consider providing ways to allow a supervisee to have quick and consistent access to supervision and support apart from formally scheduled meeting times. In addition, it may become necessary for supervisors to seek their own supervision or training around CMH settings or related to the developmental level of entry-level counselors (Fall & Sutton, 2003; Magnuson, Norem, & Wilcoxon, 1998).

Organizations that employ and depend on entry-level counselors to provide services to their clients must be aware of the stressors involved (Bell, Kulkarni & Dalton, 2003). Administrative burden should be streamlined where possible. Whereas organizations may not have the freedom to do away with certain requirements or accountability practices, ensuring support for these additional responsibilities is beneficial for the organization as well as for the counselor. Freadling and Foss-Kelly (2014) recently reported that participants in their study viewed CMH settings as temporary until they could secure their licensure. Recruiting and hiring quality employees can be expensive and draining of time and other resources. A long-term solution for organizations might be to provide training, support, and resources to entry-level

counselors, and provide opportunities for job growth, pay raises, and promotion.

Participants in this study reported that one of their primary stressors was the lack of financial support for supervision. They did not refer as much to their salary or benefits other than the burden that funding supervision causes.

Beyond the scope of this current study, significant need for focus lies in the way the mental health system and compliance policies impact service delivery in CMH settings. Whereas there is a need for efficient and cost effective mental health care, the accountability practices set forth seem to be impacting the service providers in substantially negative way. Further research is necessary in discovering problems and solutions for beneficial impact to counselors, supervisors, organizations, and ultimately the clients served in CMH settings.

Suggestions for Future Research

This study provided one of the few glances at experiences of entry-level counselors in the CMH context. To this point only a few other studies have identified significant factors related to entry-level counselors and their work or the context of their work (Freadling & Foss-Kelly, 2014; Randolph, 2010). More examination of the experiences of entry-level counselors is needed. Research that focuses on students is helpful but the needs beyond graduate school are largely unknown (Borders & Brown, 2005). Furthermore, understanding additionally how contexts such as CMH impacts counselors is equally as compelling.

Research that goes beyond the counselor experiences to supervisor experiences may give an additional perspective on the unique challenges of the CMH setting.

Supervision models and the experiences of counselor development have largely been explored in the context of counseling students in internship experiences (Borders & Brown, 2005; Dupre, Echterling, Meixner, Anderson, & Kielty, 2014). Considering that participants in this study noted feeling tested by finding supportive supervision and the administrative requirements in CMH, it seems reasonable to consider that supervisors in the CMH context may also be experiencing frustration with these unique challenges and may also have insights into the experiences of entry-level counselors.

The finding that most of the participants had noted a job change within their early experiences of postgraduate work pointed to a need for additional exploration of factors that impact job setting choice. This may be further uncovered through more extensive research with entry-level counselors in CMH settings overall. In addition, understanding the conditions of the CMH setting and the degree to which these factors are aligned with the expectations of new graduates could offer insight into how to better prepare students for CMH work. Distinctions between experiences related to nonprofit versus for profit organizations could lead to a greater understanding of organizational operations and the impact on all involved.

Use of measurements that provide more quantitative data related to the experiences of entry-level counselors in the context of CMH could provide more baseline understanding of how counselors experience wellness or impairment. This examination could assist researchers to understand more how the counselor breaks down these experiences and relate to the counselor as self. The few studies that have begun to address entry-level counselors experiences have generally relied on self-report. Use of varied

methodological explorations could lead us to a more full picture of what needs and solutions we can offer these counselors. Furthermore, if counseling programs are not able to publicly provide information regarding what their students are doing post-graduate, it may be beneficial to conduct a general survey of entry-level counselors to determine roles and responsibilities being taken on by recent graduates.

Conclusion

The counseling profession has expressed value in wellness for counselors and client welfare. Further, the emphasis on supervision at multiple levels confirms this. It appears that the setting in which counselors work or supervise has been largely overlooked. The current study contributed to the gap in literature addressing the experiences and needs of entry-level professional counselors in the CMH setting. Findings of this study provided direction for practical changes and future research that may inform a better understanding of the unique needs for post graduate counselors and supervisors in the unique setting of CMH.

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APPENDIX A

IRB APPROVAL



THE UNIVERSITY of NORTH CAROLINA
GREENSBORO

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To: Susan Blake
Counsel and Ed Development
susanblakelpc@yahoo.com

From: UNCG IRB

Authorized signature on behalf of IRB

Approval Date: 5/30/2014
Expiration Date of Approval: 5/29/2015

RE: Notice of IRB Approval by Expedited Review (under 45 CFR 46.110)
Submission Type: Initial
Expedited Category: 7.Surveys/interviews/focus groups,6.Voice/image research recordings
Study #: 14-0184
Study Title: Ready or Not: A Qualitative Investigation of the Experiences of Entry-Level Professional Counselors Working in Community Mental Health Settings and Potential Impacts to Wellness

This submission has been approved by the IRB for the period indicated. It has been determined that the risk involved in this research is no more than minimal.

Study Description:

This study will be a qualitative investigation between 8 and 10 participants. Participants will be interviewed by the student researcher using semi-structured interviews to ask related questions concerning their experiences as entry-level professional counselors working in the community mental health setting. Consensual Qualitative Research will be the research method used. The results of the study will be presented in a dissertation.

Regulatory and other findings:

- This research meets criteria for waiver of a signed consent form according to 45 CFR 46.117(c)(2).

Investigator's Responsibilities

Federal regulations require that all research be reviewed at least annually. It is the Principal Investigator's responsibility to submit for renewal and obtain approval before the expiration date. You may not continue any research activity beyond the expiration date without IRB approval. Failure to receive approval for continuation before the expiration date will result in automatic termination of the approval for this study on the expiration date.

Signed letters, along with stamped copies of consent forms and other recruitment materials will be scanned to you in a separate email. **Stamped consent forms must be used unless the IRB has given you approval to waive this requirement.** Please notify the ORI office immediately if you have an issue with the stamped consents forms.

You are required to obtain IRB approval for any changes to any aspect of this study before they can be implemented (use the modification application available at <http://integrity.uncg.edu/institutional-review-board/>). Should any adverse event or unanticipated problem involving risks to subjects or others occur it must be reported immediately to the IRB using the "Unanticipated Problem-Adverse Event Form" at the same website. Please be aware that valid human subjects training and signed statements of confidentiality for all members of research team need to be kept on file with the lead investigator. Please note that you will also need to remain in compliance with the university "Access To and Retention of Research Data" Policy which can be found http://policy.uncg.edu/research_data/.



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To: Susan Blake
Counsel and Ed Development
susanblakelpc@yahoo.com

From: UNCG IRB

Approval Date: 4/09/2015
Expiration Date of Approval: 4/07/2016

RE: Notice of IRB Approval by Expedited Review (under 45 CFR 46.110)
Submission Type: Renewal
Expedited Category: 7.Surveys/interviews/focus groups,6.Voice/image research recordings **Study #:** 14-0184
Study Title: Ready or Not: A Qualitative Investigation of the Experiences of Entry-Level Professional Counselors Working in Community Mental Health Settings and Potential Impacts to Wellness

This submission has been approved by the IRB for the period indicated.

Study Description:

This study will be a qualitative investigation between 8 and 10 participants. Participants will be interviewed by the student researcher using semi-structured interviews to ask related questions concerning their experiences as entry-level professional counselors working in the community mental health setting. Consensual Qualitative Research will be the research method used. The results of the study will be presented in a dissertation.

Study Specific Details:

Study involves DATA ANALYSIS ONLY.

Regulatory and other findings:

- This research meets criteria for waiver of a signed consent form according to 45 CFR 46.117(c)(2).
- **This research is closed to enrollment and remains open for data analysis only.**

Investigator's Responsibilities

Federal regulations require that all research be reviewed at least annually. It is the Principal Investigator's responsibility to submit for renewal and obtain approval before the expiration date. You may not continue any research activity beyond the expiration date without IRB approval. Failure to receive approval for continuation before the expiration date will result in automatic termination of the approval for this study on the expiration date.

APPENDIX B

PARTICIPANT INFORMED CONSENT

UNIVERSITY OF NORTH CAROLINA AT GREENSBORO

CONSENT TO ACT AS A HUMAN PARTICIPANT

Project Title: Ready or Not: A Qualitative Investigation of the Experiences of Entry-Level Counselors Working in Community Mental Health Settings and Potential Impacts to Wellness.

Principal Investigator and Faculty Advisor: Susan Blake, Principal Investigator; Dr. Keith Mobley, Faculty Advisor

What are some general things you should know about research studies?

You are being asked to take part in a research study. Your participation in the study is voluntary. You may choose not to join, or you may withdraw your consent to be in the study, for any reason, without penalty. Research studies are designed to obtain new knowledge. This new information may help people in the future. There may not be any direct benefit to you for being in the research study. There also may be risks to being in research studies. If you choose not to be in the study or leave the study before it is done, it will not affect your relationship with the researcher or the University of North Carolina at Greensboro. Details about this study are discussed in this consent form. It is important that you understand this information so that you can make an informed choice about being in this research study. You will be given a copy of this consent form. If you have any questions about this study at any time, you should ask the researchers named in this consent form. Their contact information is below.

What is the study about?

This is a research project. Your participation is voluntary. The purpose of this research study is to explore the experiences of entry-level professional counselors working in the community mental health setting and the impact on counselor wellness. More specifically, this study is to explore your personal experiences of professional work as a counselor in community mental health, supervision and your perception of how these impact your wellness.

Why are you asking me?

You are being asked to participate in this study because you have graduated from a CACREP accredited Master's degree program in Counseling and work in a community mental health setting within the State of North Carolina. In addition, you have indicated that you have two years of professional experience or less than 2,000 hours, but at least

one year of professional experience or 1,000 hours. You spend at least 50% of your work time in direct contact with clients. You are credentialed as LPCA in NC and receive supervision. You have volunteered to be included in the study or have been recommended to the student researcher as a potential participant.

What will you ask me to do if I agree to be in the study?

If you chose to participate in this study you will be asked to complete a detailed demographic questionnaire that will provide information related to your personal demographics, your work setting, and your supervision experiences. This questionnaire will include 19 questions and will be administered through an online survey program. In addition, you will be asked to complete an online measure that helps to identify your perception of professional quality of life and includes concepts such as (a) Compassion Satisfaction, (b) Compassion Fatigue, (c) Burnout, and (d) Secondary Traumatic Stress. The total estimated time to complete the survey portion of the study is 30 minutes. The results of the measure will be provided to you upon completion of the survey. In addition to the survey questions the study will consist of a face-to-face interview that has been found to take roughly 30 minutes. The interview questions will be provided to you prior to the interview. The interview is expected to take no longer than 90 minutes and will be conducted at a location that is convenient and confidential for you. A transcript of the interview will be provided to you upon request.

Is there any audio/video recording?

Because of the nature of qualitative research it is extremely helpful to use recordings of interviews. This allows the researcher to truly maintain the integrity of your responses to the interview questions. Interviews will be recorded using either video or digital audio recording devices.

Because your voice will be potentially identifiable by anyone who hears the tape, your confidentiality for things you say on the tape cannot be guaranteed although the researcher will try to limit access to the tape as described below. If you choose to conduct the interview through online video conferencing, your image will be recorded and your face will therefore be identifiable.

What are the risks to me?

The Institutional Review Board at the University of North Carolina at Greensboro has determined that participation in this study poses minimal risk to participants. Because the interview questions are open-ended the extent of your response will remain in your control during the entire interview. None of the questions asked in the interview will be forced response. You will be given the interview questions prior to the face-to-face meeting. Although participants will be asked about personal experiences of working with client issues, supervision experiences and wellness related to your employment setting there should be no risks to participants such that employment or reputation will be compromised.

This study poses minimal risk to participants for emotional harm or distress. In the unlikely event that a participant experiences distress related to the study a referral for services will be made. An initial evaluation for referral will be made through either the Nicholas A. Vacc Counseling and Consulting Clinic located on the campus of the University of North Carolina at Greensboro or at a practice of the participant's choice. You may contact the Vacc Counseling Clinic at (336) 334-3423.

If you have questions, want more information or have suggestions, please contact faculty advisor Dr. Keith Mobley by phone at (336) 334-5215 by email at k_mobley@uncg.edu. You may reach the student researcher, Susan Blake at sdblake@uncg.edu or by phone at (336) 355-7331.

If you have any concerns about your rights, how you are being treated, concerns or complaints about this project or benefits or risks associated with being in this study, please contact the Office of Research Integrity at UNCG toll-free at (855)-251-2351.

Are there any benefits to society as a result of me taking part in this research?

Findings from this study have the potential to inform multiple areas within the counseling field. An increased understanding of what entry-level counselors are experiencing within the community mental health setting may help educators, counselors, supervisors and organizations promote greater wellness and mitigate impairment. Society may benefit from this greater understanding of entry-level counselor experiences as well counselors are more likely to provide more effective therapeutic interventions to their clients.

Are there any benefits to *me* for taking part in this research study?

Participants may find a general satisfaction for contributing to a greater understanding of the experiences of counselors. You may experience greater insight into how you are personally and professionally managing experiences with clients, supervisors or community organizations. You will receive the results of a measure that provides feedback related to your professional quality of life.

Will I get paid for being in the study? Will it cost me anything?

Participating in this study is of no monetary cost to you.

A \$15 gift card will be provided to those who choose to participate in the study. The gift cards will be dispersed at the end of the interview process.

How will you keep my information confidential?

The student researcher will use a recording device during the interviews. The digital audio or video file will be stored on a USB drive that is password protected and only accessible by the student researcher. In addition, the USB drive will be stored in a small locked box only accessible to the researcher. A contracted transcription company will transcribe the interviews. The transcriptionist is required to sign a confidentiality statement however, no identifying information will be provided to the transcribing service. Once the audio or video file has been transcribed the audio file will be deleted.

Transcribed interviews will be coded with a numerical identifier that will be managed only by the student researcher. Other research team members will not have access to identifying information from the beginning of the study throughout the process of data analysis. All signed informed consent documentation will be completed online through Qualtrics and will be maintained in a digital password protected format.

In the event that a participant must complete the demographic survey or other measurement via paper and pencil method, the paper copy will be scanned into pdf and then shredded. The digital version will then be stored on a password protected USB drive and/ or a secure Dropbox file only accessible by the student researcher. A master list containing coded identifiers that link each participant's interview transcription with their identified survey will be maintained by the student researcher. No other individuals will have access to the master list. The list will be stored in a separate file in Dropbox as well as a separate USB, if needed. The master list files can be password protected also.

During interviews the researcher will not use your name while the audio recording device is on. This is in order to protect your anonymity. All information obtained in this study is strictly confidential unless disclosure is required by law.

Absolute confidentiality of data provided through the Internet cannot be guaranteed due to the limited protections of Internet access. Please be sure to close your browser when finished so no one will be able to see what you have been doing.

All demographic and measurement data will be collected through an online survey-collection program called Qualtrics. Qualtrics is a secure site with SAS 70 certification for rigorous privacy standards. Any data that you provide through this program will be encrypted for security purposes using Secure Socket Layers (SSL). Only the study investigators will have access to the data on Qualtrics. To protect your privacy, all participants' IP addresses will be masked by Qualtrics and will be unavailable to, and unidentifiable by, investigators or others. Qualtrics' privacy policy can be obtained at <http://www.qualtrics.com/privacy-statement>. Additional security information may be obtained at <http://qualtrics.com/security-statement>.

What if I want to leave the study?

You have the right to refuse to participate or to withdraw at any time, without penalty. If you do withdraw, it will not affect you in any way. If you choose to withdraw, you may request that any of your data which has been collected be destroyed unless it is in a de-identifiable state.

The investigators also have the right to stop your participation at any time. This could be because you have had an unexpected reaction, or have failed to follow instructions, or because the entire study has been stopped.

What about new information/changes in the study?

If significant new information relating to the study becomes available which may relate to your willingness to continue to participate, this information will be provided to you.

Voluntary Consent by Participant:

By continuing in this survey and completing this survey/activity, you are agreeing that you read, or it has been read to you, and you fully understand the contents of this document and are openly willing consent to take part in this study. All of your questions concerning this study have been answered. By acknowledging this statement and completing the interview process, you are agreeing that you are 18 years of age or older and are agreeing to participate, or have the individual specified above as a participant participate, in this study described to you by Susan Blake.

APPENDIX C
RECRUITMENT LETTER

ATTENTION LPCAs

The purpose of the study is to investigate the experiences of entry-level professional counselors working within CMH agencies and how these experiences impact their wellness.

Participate in a Research
Study about LPCA
Professional Quality of Life!!

- ☒ CACREP Master's Degree
- ☒ Work in Community Mental Health
- ☒ At least one year post-graduate or 1,000 hours
- ☒ Less than two years post-graduate or 2,000 hours
- ☒ 20-30 minute online survey
- ☒ 60-90 minute interview

Contact Susan Blake, LPCS – doctoral student at UNCG
susanblakelpcs@gmail.com
(336) 355-7331.

Approved IRB
10/30/14

EARN A \$15 GIFT CARD

If you know of someone else who may be interested in this study, please feel free to give the researcher's contact information.

Your participation in this study is always voluntary. This study has been reviewed and approved by the Institutional Review Board at The University of North Carolina at Greensboro.

APPENDIX D

LANDING WEBPAGE

https://www.google.com/url?sa=D&source=docs&u=https://www.lpcadissertationstudy.com/&usq=__g__=1

Dissertation Study - Susan Blake LPCS

Susan Blake

Share

LPCA Dissertation Study

Search this site

Dissertation Study - Susan Blake LPCS

Dissertation Study - Susan Blake LPCS

My name is Susan Blake. I am a doctoral candidate at The University of North Carolina at Greensboro working toward completion of my dissertation in Counseling and Counselor Education. I am currently recruiting participants for my study, which examines experiences of entry-level professional counselors working in community mental health settings. In addition to working on my doctoral research, I am a Licensed Professional Counselor Supervisor. I have witnessed supervisees confront challenges to their wellness in community mental health settings. I believe that it is incredibly important to explore the experiences of new professional counselors so that we as a profession can offer support. Working in a community mental health setting means that you have unique experiences that might help lead to a greater understanding of what promotes and hinders wellness among counselors similar to you.

The purpose of the study is to investigate the experiences of entry-level professional counselors working within CMH agencies and how these experiences impact their wellness. **You may be a potential participant if you have a Master's degree in counseling from a CACREP accredited program within the state of North Carolina, less than two years of post-graduate experience and are currently working in a community mental health organization within the state of North**

Approved IRB
7/30/14

APPENDIX E

SCREENING STATEMENT

IN PERSON SCREENING/ RECRUITMENT STATEMENT

Thank you for contacting me. To give you some background about me, I am a doctoral student at The University of North Carolina at Greensboro. I am working toward completion of my dissertation in Counseling and Counselor Education. I am currently recruiting participants for my study, which examines experiences of entry-level professional counselors working in community mental health settings. In addition to working on my doctoral research, I am a Licensed Professional Counselor Supervisor. I have witnessed supervisees confront challenges to their wellness in community mental health settings. I believe that it is incredibly important to explore what the experiences of new professional counselors are so that we as a profession can offer support. Working in a community mental health setting means that you have unique experiences that might help lead to a greater understanding of what promotes and hinders wellness among counselors similar to you.

The purpose of the study will be to investigate the experiences of entry-level professional counselors working within CMH agencies and how these experiences impact their wellness. You may be a potential participant if you may have a Master's degree in counseling from a CACREP accredited program within the state of North Carolina, less than two years of post-graduate experience and are currently working in a community mental health organization within the state of North Carolina. I have a brief screening form that we can discuss to ensure that you meet the inclusion criteria.

If you choose to participate in this study your feedback will be extremely valuable. You will be asked to complete a demographic questionnaire and a brief measurement that asks about your professional quality of life. This survey is estimated to take between 20 and 30 minutes. In addition to the electronic survey you will be asked to participate in a face-to-face interview that will take no longer than 90 minutes. The purpose of the interview is to obtain information regarding your personal experiences of community mental health. Because I recognize that your time is valuable the interview may be conducted at a location convenient for you. It is also possible to participate in the interview portion of the study via Skype or other face-to-face video conferencing.

If you are interested and meet the qualifications I can email you the link for the online survey that includes a consent statement and agreement to participate. Your participation in this study is always voluntary. This study has been reviewed and approved by the Institutional Review Board at The University of North Carolina at Greensboro. Participants will receive a \$15 gift card to Amazon.com. If you know of someone else who may be interested in this study, please feel free to give them my contact information.

Approved IRB
5/30/14

APPENDIX F

RECRUITMENT EMAIL

RECRUITMENT STATEMENT

Email to potential participant identified through lead researcher's existing network.

Dear _____,

My name is Susan Blake. I am a doctoral student at The University of North Carolina at Greensboro. I am working toward completion of my dissertation in Counseling and Counselor Education. I am currently recruiting participants for my study, which examines experiences of entry-level professional counselors working in community mental health settings. In addition to working on my doctoral research, I am a Licensed Professional Counselor Supervisor. I have witnessed supervisees confront challenges to their wellness in community mental health settings. I believe that it is incredibly important to explore what the experiences of new professional counselors are so that we as a profession can offer support. Working in a community mental health setting means that you have unique experiences that might help lead to a greater understanding of what promotes and hinders wellness among counselors similar to you.

The purpose of the study will be to investigate the experiences of entry-level professional counselors working within CMH agencies and how these experiences impact their wellness. You may be a potential participant if you may have a Master's degree in counseling from a CACREP accredited program within the state of North Carolina, less than two years of post-graduate experience and are currently working in a community mental health organization within the state of North Carolina.

If you choose to participate in this study your feedback will be extremely valuable. You will be asked to complete a demographic questionnaire and a brief measurement that asks about your professional quality of life. This survey is estimated to take between 20 and 30 minutes. In addition to the electronic survey you will be asked to participate in a face-to-face interview that will take no longer than 90 minutes. The purpose of the interview is to obtain information regarding your personal experiences of community mental health. Because I recognize that your time is valuable the interview may be conducted at a location convenient for you. It is also possible to participate in the interview portion of the study via Skype or other face-to-face video conferencing.

Your participation in this study is always voluntary. This study has been reviewed and approved by the Institutional Review Board at The University of North Carolina at Greensboro. Participants will receive a \$15 gift card to Amazon.com.

If you are interested or willing to participate in this study please contact Susan Blake at susanblakelpc@yahoo.com or at (336) 355-7331. If you know of someone else who may be interested in this study, please feel free to give the researcher's contact information.

I sincerely appreciate your time to consider this study.

Approved IRB
5/30/14

APPENDIX G

DEMOGRAPHIC QUESTIONNAIRE

ELECTRONIC QUESTIONNAIRE SURVEY

DEMOGRAPHIC QUESTIONNAIRE

1. What is your age? _____
2. What is your gender?
 - ☐ Female
 - ☐ Male
 - ☐ Intersex
 - ☐ Transgender
 - ☐ Other: _____
3. What is your relationship status?
 - ☐ Single
 - ☐ Married
 - ☐ Partnered
 - ☐ Divorced
 - ☐ In a committed relationship
 - ☐ Other: _____
4. How do you describe your racial/ ethnic identity?
 - ☐ Black or African-American
 - ☐ Alaska Native
 - ☐ American Indian
 - ☐ Arab-American
 - ☐ Asian-American
 - ☐ Caucasian
 - ☐ Latino/ a or Hispanic
 - ☐ Native American
 - ☐ Native Hawaiian
 - ☐ Pacific Islander
 - ☐ Multi-racial
 - ☐ Other: _____
5. Please indicate length of time since graduating with your Master's degree?

- ☐ 12 months post-graduate experience
- ☐ 13 months post-graduate experience
- ☐ 14 months post-graduate experience
- ☐ 15 months post-graduate experience
- ☐ 16 months post-graduate experience
- ☐ 17 months post-graduate experience
- ☐ 18 months post-graduate experience
- ☐ 19 months post-graduate experience
- ☐ 20 months post-graduate experience
- ☐ 21 months post-graduate experience
- ☐ 22 months post-graduate experience
- ☐ 23 months post-graduate experience
- ☐ 24 months post-graduate experience

6. Was your Master's in Counseling program CACREP accredited (if applicable)?

- ☐ Yes ☐ No

7. How satisfied were you with your Master's degree program?

- ☐ Very Satisfied
- ☐ Somewhat Satisfied
- ☐ Satisfied
- ☐ Neutral
- ☐ Somewhat Dissatisfied
- ☐ Dissatisfied
- ☐ Very Dissatisfied

8. How prepared from your Master's program do you feel you are to do the work you do?

- ☐ Very Prepared
- ☐ Prepared
- ☐ Neutral
- ☐ Somewhat Unprepared
- ☐ Unprepared
- ☐ Very Unprepared

9. Describe the professional license your supervisor holds?

- | | | | |
|--------------------------------|-------------------------------|------------------------------|---------------------------------------|
| <input type="checkbox"/> LPCA | <input type="checkbox"/> LPC | <input type="checkbox"/> LCP | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> PLCSW | <input type="checkbox"/> LCSW | <input type="checkbox"/> MD | <input type="checkbox"/> LPCS |

10. Indicate the amount of professional experience your supervisor has.

- ☐ 1 – 5 years ☐ 10 – 15 years
☐ 6 – 10 years ☐ 15 + years

11. On average, how many hours of individual (or triadic) supervision do you receive per month?

- ☐ 1 ☐ 6
☐ 2 ☐ 7
☐ 3 ☐ 8
☐ 4 ☐ 9
☐ 5 ☐ 10+

12. On average, how many hours of group supervision do you receive per month?

- ☐ 1 ☐ 6
☐ 2 ☐ 7
☐ 3 ☐ 8
☐ 4 ☐ 9
☐ 5 ☐ 10+

13. In what setting do you currently practice counseling? (check all that apply)

- ☐ Hospital In-Patient
☐ Hospital - other
☐ Nonprofit community agency
☐ For profit community agency
☐ Domestic violence shelter
☐ Group home
☐ Substance abuse treatment facility
☐ Other

14. How long have you been employed in your current setting? _____

15. Have you been employed previously since obtaining your graduate degree in counseling? ☐ Yes ☐ No If so, what setting? _____

16. On average, how many clients do you see in a week? _____

17. Regarding the clients you counsel please check all issues that apply to these clients.

- | | |
|---|---|
| <input type="checkbox"/> Trauma | <input type="checkbox"/> PTSD |
| <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Child Abuse |
| <input type="checkbox"/> Rape/ Sexual Assault | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Personality Disorders | <input type="checkbox"/> Anxiety Disorders |
| <input type="checkbox"/> ADD/ ADHD | <input type="checkbox"/> Grief/ Loss |
| <input type="checkbox"/> Marriage/ Family | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> LGBT | <input type="checkbox"/> AIDS/ HIV |
| <input type="checkbox"/> Anger Management | <input type="checkbox"/> Critical Incident Response |
| <input type="checkbox"/> Autism/ Asperger's | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Disability Issues | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Housing and Homelessness | <input type="checkbox"/> Psychosis (i.e. schizophrenia) |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Addictions (other) |
| <input type="checkbox"/> EAP | <input type="checkbox"/> Adults |
| <input type="checkbox"/> Children | <input type="checkbox"/> Adolescents |
| <input type="checkbox"/> Other: _____ | |

18. Of the above issues that apply, please indicate the estimated percentage of your caseload that involves each of the issues.

- | | |
|--------------------------------|--------------------------|
| Trauma _____ | PTSD _____ |
| Sexual abuse _____ | Child Abuse _____ |
| Rape/ Sexual Assault _____ | Domestic Violence _____ |
| Personality Disorders _____ | Anxiety Disorders _____ |
| ADD/ ADHD _____ | Grief/ Loss _____ |
| Marriage/ Family _____ | Bipolar Disorder _____ |
| LGBT _____ | AIDS/ HIV _____ |
| Anger Management _____ | Critical Incident _____ |
| Response _____ | |
| Autism/ Asperger's _____ | Depression _____ |
| Disability Issues _____ | Suicide _____ |
| Housing and Homelessness _____ | Psychosis _____ |
| Substance Abuse _____ | Addictions (other) _____ |
| EAP _____ | Adults _____ |
| Children _____ | Adolescents _____ |
| Other: _____ | |

19. What funding sources does your community organization utilize? Check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Self-pay |
| <input type="checkbox"/> Grant-funding | <input type="checkbox"/> IPRS/ County funding |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Private Health Insurance |

APPENDIX H

PRO QOL MEASUREMENT

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE (PROQOL) VERSION 5 (2009)

When you *counsel* people you have direct contact with their lives. As you may have found, your compassion for those you *counsel* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *counselor*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1 = NEVER 2 = RARELY 3 = SOMETIMES 4 = OFTEN 5 = VERY OFTEN

1. I am happy.
2. I am preoccupied with more than one person I *counsel*.
3. I get satisfaction from being able to *counsel* people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I *counsel*.
7. I find it difficult to separate my personal life from my life as a *counselor*.
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *counsel*.
9. I think that I might have been affected by the traumatic stress of those I *counsel*.
10. I feel trapped by my job as a *counselor*.
11. Because of my *counseling*, I have felt "on edge" about various things.
12. I like my work as a *counselor*.
13. I feel depressed because of the traumatic experiences of the people I *counsel*.
14. I feel as though I am experiencing the trauma of someone I have *counseled*.
15. I have beliefs that sustain me.

16. I am pleased with how I am able to keep up with *counseling* techniques and protocols.
17. I am the person I always wanted to be.
18. My work makes me feel satisfied.
19. I feel worn out because of my work as a *counselor*.
20. I have happy thoughts and feelings about those I *counsel* and how I could help them.
21. I feel overwhelmed because my case load seems endless.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *counsel*.
24. I am proud of what I can do to *counsel*.
25. As a result of my *counseling*, I have intrusive, frightening thoughts.
26. I feel "bogged down" by the system.
27. I have thoughts that I am a "success" as a *counselor*.
28. I can't recall important parts of my work with trauma victims.
29. I am a very caring person.
30. I am happy that I chose to do this work.

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APPENDIX I

INTERVIEW QUESTIONS

IQ 1: To get started, I want to learn a little about your experiences of being an entry-level counselor in a community mental health agency. Tell me about your job and role as a counselor in a CMH setting.

IQ 2: Researchers have found that experience level of counselors and the setting of CMH sometimes impacts counselors' experiences of things related to professional quality of life. I would like to talk about the Professional Quality of Life scale that you completed. Please describe what your experience was like taking this survey. What thoughts or feelings about your own experiences as an entry-level counselor working in CMH did it bring up for you?

IQ 3: Tell me about why you chose to work in a CMH agency?

IQ 4: In CMH organizations there are usually additional job responsibilities or duties along with client care such as paperwork, documentation, technology, insurance, Medicaid, compliance, etc. What has your experience of these types of things been since starting in the CMH setting?

Probe: How do you see these impacting your ability to work as a counselor?

IQ 5: Describe the types of clients and client issues that you work with in the CMH setting?

IQ 6: How do you think that the issues your clients face regularly, impacts you both professionally and personally?

IQ 7: What prepared you to deal with your work as a counselor?

IQ 8: How do you deal with stress or self-care?

IQ 9: It has been considered that counselor development is facilitated by supervision. In addition, it is a requirement for entry-level professional counselors. Describe your supervision.

IQ 10: Discuss any positive and negative components of supervision for you in the setting of CMH?

Possible probes related to development:

Critical incidents –

personal reactions

philosophy of counseling

competence

professional identity

supervision

APPENDIX J

RESEARCH TEAM PREPARATION

Agenda for Initial Meeting of Research Team.

Initial Readings Cited: Hill et al., 1997; Hill et al., 2005; Hill et al., 2012

Date: 3/4/14

Introductions/ Greetings

Discussion of Team Dynamics

- Review of roles on CQR team

- Brief discussion regarding power differences

Discussion of the Topic

- Brief review of literature - Research Question Grid

- Purpose of the study

- Review of research questions and interview questions

- Timeline and expectations of CQR team

 - What will be expected?

 - How will you carry this out?

 - When will you need to complete it?

Training

- Review of general CQR process by embedded experts

- Discussion of CQR articles and book chapters

- Embedded experts answer general questions

Bracketing Exercise

- Review of bracketing questions

- Discussion of responses

- Agreement of *Implications of Bracketing Exercise*

Conclusion

- Email / contact exchange

- Reschedule potential follow up meeting

APPENDIX K

BRACKETING EXERCISE

Prior to the pilot study, the members of the research team met to discuss general CQR protocol and specific needs related to this study. During that meeting the team reviewed answers to questions posed regarding bias and expectations of the research team. The questions were emailed to team members for consideration. Members were encouraged to list answers to the questions to bring to the meeting. The team met and discussed the questions openly. The questions and responses are listed below.

What were your personal experiences with being an entry-level counselor?

- I struggled with having a helpful supervisor and relied on my own resources and supports frequently. I also struggled with thinking I "should" know more or be more independent. It would've been helpful to have more supervisory support to normalize and manage those thoughts and provide more feedback and direction than me having to seek peers, find information, or learn by experimentation. I also recall feeling pretty efficacious on my own which motivated me, but I wonder how efficacious I really was since I didn't have direct feedback much.
- My personal experiences with being an entry-level counselor involved a lot of confusion and stress. There was a lot of expectation to know how to navigate the social welfare and mental health system that I was not prepared for during grad school.
- After graduation from my Master's program, I went straight into a doctoral program. I was able to count my hours from my Master's internship towards licensure. I completed my Master's internship working mostly with college-aged students. I did 3 semesters of internship in my doctoral program, one at a CMH agency and, and two with a hospital pastoral care program, working primarily with patients with cancer. To complete my licensure hours, I worked part-time as a child/adolescent mental health therapist at a CMH agency during my last year of the doctoral program and was able to complete my hours within a few months of work and receive my license. Due to going straight into another graduate program, I received intense supervision for much of the time I was gaining hours towards licensure being under both university and site supervision. In this way, my experience is likely to differ from many other entry-level counselors' experiences of supervision.

- In some ways I felt a sense of "I need to do this on my own" and figure things out. After a while, and getting to know my colleagues better I felt very supported. I realized people didn't expect me to be where they were, even though we held the same position. My first professional position was at a place that emphasized teaching and supervision, so they were very developmental.

What experiences did you have within the community mental health setting? What are your personal experiences and beliefs about working with organizational factors?

- I worked at a community mental health center and residential program with few supports and resources and a high-level of autonomy. I remember more problematic employees getting more attention and the assumption being "if they aren't messing up (e.g., receiving complaints, creating ethical or legal dilemmas, having clients decompensate or fail to progress), then they are doing great". This led to promotions and greater responsibility; however, "not messing up" is not a great reason to assume competence or leadership potential.
- I have spent the majority of my career in the CMH setting. I have only recently transitioned into private practice. I have experienced a great deal of stress dealing with mismanagement and disorganization within the CMH setting. I believe that the problems stem from systemic issues that reach as far as our state and federal mental health policies and practices. I believe that individual organizations could implement leadership that is effective at managing difficult organizational issues that impact counselors and clients.
- My university internship served the community but I worked with primarily college students. When I think of my experience of community mental health, I think primarily of my work at CMH agencies. I worked with all age ranges in these settings, and many clients with more severe or acute mental health issues. My experience was that these agencies were not equipped to handle the number of clients as well as the acuity of their presenting issues. Due to the lack of staff, many clients were only able to be seen bi-weekly or once a month, or forced to go into groups for weekly counseling, which may or may not have been appropriate for the clients. Treatment planning was then limited by these services, and treatment for the client was dictated more by what services were available rather than what would actually be the most beneficial treatment for their presenting issue. Although I found staff meetings helpful to have a space to discuss clients with supervisors and/or psychiatrists in the midst of a busy work schedule, overall, I found these agencies lacked in the coordination of services, both internally and externally with other agencies, community organizations, or schools. The organizational factors impacted my ability to help clients, and I often felt ineffective in addressing their issues. This led me to feeling burned out quickly in a short period of time as I struggled to develop relationships with

clients due only seeing them once a month and only the higher functioning clients tended to show progression, making it hard at times for me to find meaning in my work.

- My very first counseling experience after finishing my Masters was in a community (hospital outpatient) setting. I distinctly remember my supervisor saying "I don't do supervision like that" when I explained about needing an hour of supervision each week. She was willing to talk and answer questions, but it was not the traditional sit down for 50 minutes, listen to a recording of my sessions and get her feedback.

What are your personal experiences and beliefs about working with challenging clientele?

- I found early on that challenging clients should be a team effort, but if they aren't then it creates greater isolation. It's a critical aspect of managing acuity of case loads for any counselor, especially entry-level. I also believe that's where creativity and development of conceptual skills is gained.
- I have experience working with challenging clientele with a variety of diagnoses. I believe that everyone is capable of some change and management of symptoms or behaviors. I believe that counselors do not create the change for difficult clients but offer support and direction. I also believe that when clients' basic needs are not met, they are not in the position to work effectively on their underlying mental health concerns.
- I think client/therapist fit and the therapeutic relationship is essential to working with challenging clients. When I worked at one particular CMH agency, I was the only therapist for 6 months of my employment there, and so I was unable to refer the client if I did not feel we were a good fit for each other, unless I referred outside of the agency. Many other agencies in the area had waiting lists too, and so it was difficult to find a place to meet their immediate needs. I then to use MI when working with challenging clients. Sometimes when I do get frustrated, and I tend to question my abilities rather than put the onus back on the client, especially as a new therapist.
- I believe that counselors working with challenging clients and complicated presenting issues (trauma, CSA, etc.) need to know where to go to find best practices as well as having appropriate supervision and/or consultation available to them.

What are your experiences and beliefs regarding counselor wellness and impairment for entry-level counselors?

- I believe entry-level counselors have a fear based decision-making process. Will I mess up, harm the client, disappoint or anger my supervisor? Fear-based attitudes are not conducive to healthy/well perspectives, and make one vulnerable to impairment. That said, I also think that the right supervisor can enter the decision making process, instill skills in that arena, and counter impairment. Organizational support for having effective supervisors and supervision practices is critical.
- I believe that it is ultimately each counselor's responsibility to manage his or her own wellness. In addition, I do think supervisors and leadership can encourage wellness. Specifically for me, wellness as an entry-level counselor was a challenge due to high demands and low support.
- I was very young when I entered this profession and idealistic. Although my training during my Master's program was superb, I found that often it was based on the ideal scenarios of working with clients, and not a lot of the practical and organizational issues of community mental health were explored during my coursework. I love working with clients, but find myself getting frustrated and feeling beat down by a system that I (feel I) have little power to change. The community mental health system does not seem to have client care as it's primary focus, in large part because our state puts little emphasis on the importance of prevention and adequate, evidence-based treatment for mental health. I found I had to pick my battles for advocacy with clients and that at times; my professional opinion was not respected by my supervisors. Again, all this led to me questioning my abilities and effectiveness, and enhanced my anxiety as a new counselor. Further, there was little focus on the wellness of the staff in the agencies where I worked, so this also makes it difficult to impact client wellness if this value is lacking in the overall structure of the agency. The way I made myself more well was by focusing on what I could control in the moment, and building and relying on a network of colleagues who could validate and support me in my experiences.
- The counselor him/herself is the tool, the instrument of the counseling process. If the instrument is broken, burned out, or otherwise compromised due to diminished wellness I believe client outcomes will be less positive or not occur in as timely a fashion had the counselor's wellness been more balanced. I believe counselor impairment comes as a result of lacking awareness of his/her own issues, which might lead to counter-transference and thus impede the counseling process. Having said this, I believe entry-level counselors may struggle with this more than do seasoned counselors as they work to balance several different areas of life (work, family, leisure, spirituality).

What are your expectations for wellness and impairment for counselors overall?

- I expect it to be developmental and that longevity in a profession should not lead to burnout. Rather, burnout is a result of never having had effective coping or practice salutogenic behaviors to begin with. The window for establishing wellness-focused behavior is limited to trainees and entry-level counselors; after that it isn't likely to be established.
- I think each counselor must take responsibility for his or her health and wellness. This may include personal habits as well as professional support such as supervision.
- Not only is our job emotionally draining, but organizational and systemic factors can make our jobs mentally and physically draining as well. There's often not enough time in the day to complete paperwork or handle casework issues, since the way of making money in this profession is by client contact hours. I think this leads to many counselors not practicing self-care. I think it also lead to counselors detaching themselves from their work in order to make it through their workday. Although counselors value and promote wellness, I think counselors may have trouble implementing these values in their personal lives, in large part due to the nature of the work in community mental health.
- I expect counselors to attend to their own wellness as a prerequisite for being able to competently do their jobs. I expect counselors to have a sense of what their limitations are.

What expectations do you have about entry-level counselors and their experiences of supervision?

- I think it is likely that entry-level counselors will appraise their supervisors dichotomously, either "good" or "bad", rather than have much complexity in their differentiation of which aspects are helpful and which are not helpful.
- My expectation ideally is that entry-level counselors will have quality effective supervision. My expectation realistically is that many counselors will report that their supervision is lacking. This would be particularly in the CMH setting as they face time and financial constraints.
- Due to organizational factors, supervision for many entry-level counselors is often focused on completion of paperwork or administrative tasks, rather than development of counseling skills. I think that upon graduation, very few entry-level counselors receive quality supervision at the level promoted as the standard

by the profession.

- I believe entry-level counselors look forward to supervision as a time to increase their understanding of a client's issues and possibly get a different perspective of how to conceptualize their client from their supervisor.

Describe your interest in participating in this research study.

- I enjoy CQR and exploring meaning-making with team members. I also want to help inform the helping professions of effective strategies for training and retaining entry-level counselors.
- I am interested in understanding the experiences and needs of these newer counselors as a supervisor and potential counselor educator.
- I enjoy research and was asked by the lead investigator to participate because she knows I have experience using CQR. Due to my own struggles as an entry-level counselor and witnessing others' struggles, I think there is a need to change our approach to counselor training to better prepare entry-level counselors for the practical and systemic issues they will likely face in their first positions after graduation.
- I am interested in contributing to the body of literature on counselor education and supervision

Identify any expectations you may have regarding the findings of this study.

- I believe there are underlying personality types/coping strategies that presuppose an entry-level client to eschew impairment and attain a minimum amount of wellness. I believe that supervision will be a key difference in the supervisee's experience
- I expect to find that entry-level counselors report a limited sense of wellness while working in the CMH setting.
- I think it's likely that the participants will report work-related stressors that impact their overall wellness. I also think it is likely that they will report a lack of confidence and/or preparation to address the client issues they encounter in practice, and a lack of quality supervision if received within their agency and not by an outside LPC-S who they are paying for supervision. I also expect that most of the participants are not planning to stay in their current positions long-term. I hope we will get a better, more concrete picture of the types of clients and casework issues that entry-level counselors actually experience in community

mental health.

- I do not have specific expectations about findings for this study.

Are there any other experiences or beliefs that might influence your work on the research team?

- As a long-time supervisor and counselor educator, I believe I may examine lived experiences of supervisee's through the lens of developmental models of supervision.
- N/A
- None not stated above
- I have some anecdotal experiences of supervising entry-level counselors and can remember my entry-level experiences. I do not believe this will unduly influence my work on the research team.

APPENDIX L

RESEARCH QUESTIONS RELATION TO INTERVIEW QUESTIONS

Research Question	Purpose	Interview Question
No research question associated.	General conversation to segue into interview. Data regarding job titles are reported.	IQ 1: To get started, I want to learn a little about your experiences of being an entry-level counselor in a community mental health agency. Tell me about your job and role as a counselor in a CMH setting.
RQ1: What are the overall experiences of newer professional counselors working with community mental health settings?	To gain a contextual understanding of the PROQOL for entry-level counselors.	IQ 2: Researchers have found that experience level of counselors and the setting of CMH sometimes impacts counselors' experiences of things related to professional quality of life. I would like to talk about the Professional Quality of Life Scale that you completed. Please describe what your experience was like taking this survey. What thoughts or feelings about your own experiences as an entry-level counselor working in CMH did it bring up for you?
RQ1. What are the overall experiences of newer professional counselors working within community mental health settings?	<p>1. To understand the general experiences of entry-level counselors within the unique context of CMH counseling.</p> <p>2. To continue to bridge the gap in the literature related to post-graduate experiences of counselors both at the entry-level and for professional counselors in general</p>	IQ 3: Tell me about why you chose to work in a CMH agency?

Research Question	Purpose	Interview Question
RQ2. How do entry-level counselors working in community mental health settings perceive the impact of client factors on their counselor wellness?	1. To explore experiences and needs entry-level counselors have related to clientele in the CMH setting and the potential impacts this has on wellness.	IQ 5: Describe the types of clients and client issues that you work with in the CMH setting.
RQ3. How do entry-level counselors working in community mental health settings perceive the impact of organizational factors on their wellness?	To gain an awareness and understanding of the experiences and needs of entry-level counselors related specifically to organizational factors in the CMH context.	IQ 4: In CMH organizations there are usually additional job responsibilities or duties along with client care such as paperwork, documentation, technology, insurance, Medicaid, compliance, etc. What has your experience of these types of things been since starting in the CMH setting? IQ 7: What prepared you to deal with your work as a counselor?
RQ4. How do entry-level counselors working in community mental health settings perceive the impact of supervision on their wellness?	To explore both the experiences of supervision for entry-level professional counselors in the context of CMH and the role this may have in maintaining or managing counselor wellness.	IQ 9: It has been considered that counselor development is facilitated by supervision. In addition, it is a requirement for entry-level professional counselors. Describe your supervision. IQ 10: Discuss any positive and negative components of supervision for you in the setting of CMH.

Research Question	Purpose	Interview Question
RQ5. What experiences suggest that community mental health agencies encourage the promotion of wellness and the mitigation of impairment among newer professional counselors?	To understand the unique role that organizations may have in promoting wellness for entry-level counselors and limiting impairment experiences of counselors.	IQ 6: How do you think the issues your clients face regularly impacts you both professionally and personally?
RQ6. What experiences may negatively impact wellness for newer professional counselors in community mental health settings?	To gain an awareness and understanding of general experiences that may be negative impacts to entry-level counselor wellness within the specific context of CMH settings.	IQ 8: How do you deal with stress or self-care?

APPENDIX M

PARTICIPANT INTERVIEWS

PARTICIPANT 1

Interviewer: OK, I think we've got it set up. All right. Well, how are you this morning, other than technical difficulties?

Participant: I'm good! I'm good, yeah.

Interviewer: Good. All right. So, I know it's been, probably, a few weeks now, since you've done the online survey portion of this, but I will be pulling a little bit of information from it. You already know all of the answers, though, it's no big deal. I think you'll know what we're talking about. One of the things I wanted to fill in for you is, for some reason, everybody has been skipping the age question. I think it's just maybe how it's been placed. So, I'm wondering if you would share your age with me.

Participant: Oh, yeah, I'm 33.

Interviewer: OK. Yeah, I don't know, a lot of people have missed it, so it must have been something about how it showed up in there. Yeah. OK, no, that's great. All right. I just wanted to get started by asking you a little bit about your role, and your general job title, and things that you do in your current community-based position, so if you could tell me a little bit about that.

Participant: Well, I am an out-patient therapist caring for children.

Interviewer: OK.

Participant: And I work with ... I think my youngest client is 10, and my oldest client is 20, so I have quite a range, there. And they've got a variety of issues. Most of them are dealing, I would say, with anxiety and depression type stuff.

Interviewer: OK.

Participant: I guess that's kind of it in a nutshell. I also do assessments for clients that are coming in. We have about 30 therapists. We have, I think there's four of us that are actually on staff, and the rest are contract therapists. So, I do, along with the program coordinator, I do the assessments from anybody coming in. That's all the way from little teeny tinies, I think I've done an assessment for a two-year-old, all the way up to adults.

Interviewer: OK.

Participant: And determining what services and what therapists they would probably fit best with.

Interviewer: OK. So, that's a big part of your role, is the assessment piece of it, and you also do therapy, out-patient therapy. So, you are on staff with the organization?

Participant: Yes. Yes.

Interviewer: And a lot of other folks are on contract.

Participant: Right. Yes.

Interviewer: OK. Yeah, that's helpful. Kind of shifting gears briefly here, one of the things that I had you fill out as part of that online survey piece was the professional quality of life scale. It was there at the end.

Participant: Yeah.

Interviewer: One of the reasons I included that was because researchers have found that either the experience level and the setting of counselors can impact how they experience professional quality of life, so that's part of the larger question I have here, in this research study. And I just wanted to give you a chance to talk a little bit about your experience taking that measurement, if you can remember if it brought up any thoughts or questions for you.

Participant: It didn't, really. I mean, I guess with my professional quality of life, I always tell people this, because people are always, like, "How do you not take your work home with you?"

Interviewer: Right.

Participant: And it's hard, because I'm a counselor and therapist, and I've always got that hat on, and people are always telling me in my personal life to take it off!

Interviewer: Yeah.

Participant: I guess I kind of have a metaphor for my professional quality of life, and how I keep it where it is. And it's funny, because if you'd have asked me this maybe three months ago, when I was in my last job, I probably would have had a completely different answer, because it was very difficult, then. But I still use this metaphor that I learned in my internship, or kind of developed in my internship of , I worked with what I call acute care stabilization hospital. I worked in the adolescent unit, so I say, "kids," the kids were there, I think, at most for a month and then they would step down, or they would go to a higher level of care, if necessary. Most of them were there for about two to three weeks. But it was locked. So, my metaphor was that, when I left for the day and I locked the door, I left everything there. And I tried not to take it home with me. Of course, there are still instances where I take my work home, I think about stuff, it affects me. I worry about my clients, especially if they're suicidal, or that far into the spectrum.

Interviewer: Right. I like that metaphor.

Participant: But yeah, I try not to. I try to engage myself in activities and things in my personal life that are not counseling-related.

Interviewer: OK, yeah, good. You said that if you had answered these questions maybe three months ago, it would have been different. So, you can tell a difference in job to job, how you would have responded. So, doing those questions sort of brought that out for you, that this current position seems to be good, helpful in how you manage stress and self-care issues?

Participant: Yeah, absolutely.

Interviewer: All right, and looking at your scores, you definitely scored very high on the compassion satisfaction scale. And you scored fairly low and healthy on the secondary traumatic stress and burnout, so that's good news!

Participant: Like I said, three months ago, I was in a totally different job, I was doing in-home counseling. And it was basically a 24/7 job, and I did that for two years.

Interviewer: OK.

Participant: Yeah, it was very intense. I learned a lot, but it was very quick burnout, because it was so intense. It was just really different from what I'm used to in my current job, so my current job is a much, much less level of stress. Different stress, but more manageable.

Interviewer: OK. So, if you had to answer those questions while you were doing that in-home work, was it intensive in-home?

Participant: Well, it was MST.

Interviewer: OK.

Participant: Yeah, so it's very similar to intensive in-home, but we didn't have a team, it was just us, just one therapist, which, there are pros and cons to both. But it was a lot of work, and now I get to choose my clients.

Interviewer: OK.

Participant: In my current job, If I do an assessment and there's a client that comes in, and I'm, like, man, I really vibe with this kid, I really want to work with them, I like their family, I like their story, I can deal with this, I can keep my client, whereas before they were just assigned to me, and so I was kind of stuck with some not so nice people.

Interviewer: Right. No, that's good information. I certainly can relate to that. OK, well, tell me a little bit, then, about why you chose to work in community mental health.

Participant: Well, I do have a school counseling certification as well, so I could work at a school, I'm qualified to work at a school. I just ... When I did my internship in the school, I didn't feel challenged. And everyone's always, like, well, what age would you work with if you could pick an age? And I was, like, middle school! Everyone's, like, you're crazy! That's the age I feel like, as far as working with kids, that's where they have the most challenges. That's where they're going through so much change, from puberty and all that kind of stuff, and learning to kind of figure out who they are, and their place, kind of, and they're moving into teenage-dom, and all that horribleness that comes with that.

But it's just, I worked, when I did my school counseling stuff, I just didn't feel challenged as much. And I really enjoy the variety, and not ... In a school setting, you kind of have to work, it's like a teacher, you have to work to a curriculum. You can still do your counseling, but you're going into the classroom; you're teaching skills which is really awesome. But at the same time, it's not as freeing as being in the community, and being

able to really work with families, and work on things that are outside the school setting.

Interviewer: OK. So, you started out in school, and then realized that that just didn't feel challenging enough. You didn't feel like you were able to get in there and really help with some of those problems that you saw. Instead of working to a curriculum, you totally shifted gears and went out into community-based work, where you still see all of those problems, probably multiplied, I'm guessing.

Participant: Yeah, you get more intensive with them, for sure.

Interviewer: Yeah.

Participant: Yeah. I'll just point out, I didn't start out in school counseling. I started out doing just regular community ... My master's is in community health, community mental health.

Interviewer: OK.

Participant: And then I went back, they started a program at my graduate school for school counseling, and basically, since I had already done the community mental health stuff and had my masters, it was just a year add-on. And I couldn't find a job, so I went back and got my certificate, my add-on certificate, for school counseling.

Interviewer: OK.

Participant: So, I started in community, then went to school, then could not find a job.

Interviewer: OK.

Participant: So, I started in community, then went to school, then could not find a job, and all that good stuff.

Interviewer: OK. So, it was a challenge to find a job, and that pushed you back to school counseling, and you were able to find something later in community work, obviously.

Participant: Yes.

Interviewer: OK. OK, that's good. All right, one of the things that we know is in community mental health organizations, we sort of have additional responsibilities besides client care, things that I could say as examples are paperwork, documentation, maybe even use of certain technologies, Medicaid, difference compliance pieces, things like that. So, we know that is part of that additional work that you have to do, besides client care. So, I'm wondering if you can talk a little bit about what your experience has been with those types of things. And you can pull on your previous role as well, because it all piles up in there, together.

Participant: Yeah, for sure. Well, in my last job, the extraneous work was part of the reason why I felt I had to leave, because it was paperwork, paperwork, paperwork, paperwork, paperwork. And I did not feel that I was using my counseling and therapy skills to the extent I should have been, because it was more focused on paperwork, and it was more focused on the specific technique. It was in line with what I like to do, which is CBT stuff, but it was just too specific. I'm not a box person.

Interviewer: Yeah.

Participant: Especially in counseling, I feel like you have to have all those different things in your bag; you can't just put people in one box, because it doesn't fit for everybody.

Interviewer: Right.

Participant: I felt like in my last job, the focus was so much on paperwork, and we have to get this done, and the timelines, and it was very business-oriented; whereas now, it's more practice-oriented. I still have the paperwork, I still have the documentation, but it's not near as much, and it's not near as complex.

Interviewer: OK.

Participant: Whereas before, I had to do a weekly plan, now I just have to do a yearly treatment plan. And I just have to basically keep up with ... And I'm just talking about my out-patient people. I just have to do a note after each session, and put it in, and that takes me about ... My sessions are 45 minutes, and the note usually takes me the 15 minutes in between. So, it's much less expectation with that. And in my last job, I felt that I wore more hats. I was the therapist, I was the on-call counselor. I was the case manager. I was, you know, the coordinator of all the meetings, and I had to do this stuff on top of all the paperwork. Now, it's like I just get to be the therapist.

Interviewer: OK.

Participant: And I can focus on honing my skills and doing that, where I'm not juggling all these hats in the air, which is why I like to do it, I can work with the families. If I need to be in contact with the school, I can contact the school, but it's not like I have to do that.

Interviewer: Right. And so it's not ...

Participant: If it's necessary, I will.

Interviewer: ... yeah, so it's not, you said a box, it's not put in a box, whereas ... The MST stuff, I'm guessing, was very evidence-based, and you had to use the formula and that kind of thing, to ...

Participant: Yeah. And it works for some. Some of my families it worked really well with, and others were, like, well, this is crap, right? Get out of my house! And I'm, like, OK, I felt like a robot sometimes going in. Some of the families would really get it and it worked with them, and it was great. But then others, they just didn't want you to be there at all, and they were forced into it because it was court mandated, and they didn't want to be there. Whereas my clients now, their parents are bringing them in, so they probably don't want to be there, but it's not mandated.

Interviewer: It's not mandated.

Participant: Yeah.

Interviewer: And it sounds like it's not the whole family, necessarily, that you're working with now?

Participant: Yeah.

Interviewer: OK.

Participant: Yeah, it's more individual based. I mean, I do still work with the family, I still work with the parents, and I've got one family, she's got sisters, and they come in, so I work ... If it's necessary, I'll bring the sisters in and talk to them, and kind of get their input on things. But it's my discretion. If I want to make it more individual or make it more family, how I see fit. It's not like I have to do this, whereas in MST, it's, like, "Why aren't you calling the school?" And I'm, like, "Well, there's not any school problems, the kid's making straight A's, it's mostly at home."

Interviewer: Right.

Participant: You know, "Let's focus on the home." And it was, like, "Well, you still need to be in touch with the school." It was, like, is that really clinically necessary? So, it's at more my discretion if I feel like those people need to be involved.

Interviewer: Yeah, so it gives you more freedom to do what you feel will work with your client.

Participant: Yeah. Right.

Interviewer: That's a really great feeling. Yeah, so in terms of the Medicaid note model and documentation ... I saw that eye roll! Yes! So, you do the CCA's?

Participant: Uh-huh. Yes.

Interviewer: And then when you do therapy on that out-patient basis, then you're just doing the note and the treatment plan, which is that longer-term treatment plan.

Participant: Yeah.

Interviewer: OK. What ... I guess I'm curious about your experience when you first started out in community mental health and were faced with all of this new Medicaid model paperwork? How did you adjust to that?

Participant: But it's always changing. It's always changing. You're constantly having to keep up with all of this crap, it's like ... And I guess that's why I've always ... Because of course, as a graduate student, I was, like, "Oh, I'm going to have my own private practice, and I'm going to save the world," lots of ideas, where I didn't realize all of those ... Like those notes overhead, and dealing with all of these different ... besides this Medicaid, and all these insurance entities, and everybody's different. So, I guess it's why I like kind of where I work now, because ... Well, right now, I can only bill under Medicaid.

Interviewer: OK.

Participant: But I've got people there to run the business side of it and explain things to me and say, "OK, you can do this, you can't do this. You can't accept Health Choice, but you can accept Medicaid. You can take a private pay client," and blah blah blah blah. Helping me understand and kind of navigate all of that system, and understand what's what, and how to kind of keep track of different things. So it's kind of like being in a private practice, but having someone run the business side for you.

Interviewer: OK. So, you don't have to worry about the billing piece of it, you don't have to interact with the Medicaid billing at all?

Participant: No. Yeah, no. I don't have to ... I mean, I just put in my note, and what it bills under and that kind of stuff. Then the business administration people in our agency take care of all that, and contacting people. And if we've had ... Like, I can't bill under insurance, because I'm not on any panels. But if I was on a panel, and I had a problem with billing, I mean, I guess I could call them, but the business people, like the office manager, she does some of that, too.

Interviewer: Good. So, you don't have to. You don't have to call any, you don't have to mess with that.

Participant: Yeah. We don't have to. If we don't want to, if we don't have the time, we can say, "I'm having trouble getting this billing in, and it's with Blue Cross," blah blah blah blah blah, and she'll call and try to sort it out for us.

Interviewer: One of the things that I've been hearing from a lot of people is that they have ... I guess the title has been Utilization Management Person, or someone that kind of manages those authorization pieces.

Participant: Yeah.

Interviewer: Is that what you're describing?

Participant: Yeah, I don't think there's a specific ... Well, I think there are, but I think it's just a small group of people within our agency. Not that our agency is super big, but there's two or three people that know how to navigate that system better than the therapists probably do, because they interact with them on a daily basis.

Interviewer: OK.

Participant: I know how to get those authorizations through and all that kind of stuff. And if there's any questions or things like that, they know how to get through the system to contact who they need to contact.

Interviewer: Good. Good. So you have some support on those business side pieces, that's good.

Participant: Mm-hmm. Yeah.

Interviewer: Thinking about all of the paperwork experiences, and just all those extra things that have to be done to manage in-agency work, can you talk a little bit about how you see those impacting your ability to do work with clients, or your work as a counselor?

Participant: You mean with all the extraneous paperwork and stuff? Yeah.

Interviewer: Yeah.

Participant: Like I said, at my last job, I felt like all I was doing was having them sign a PCP, or having them sign a treatment plan, or having them sign team meeting forms, and all this ... And they were really another ... and then MST is all about evidence-based, so it was constantly giving them surveys. People were calling them with surveys, we were handing them surveys. And they were, like, "Enough's enough with the paperwork!" And I'm, like, "Tell me about it!" I know! I didn't feel ... I felt like all I was

doing was having them sign pieces of paper, which we would go over them and review them, but it was a chunk of what I had to do every time I went to a client's house. It was, like, "OK, before we get started, we got to sign some paperwork." And it just felt like I wasn't able to ... It was almost like Common Core, with schools, when you're teaching towards the test. I felt like I was working towards the paperwork!

Interviewer: OK. So, counseling towards the paperwork instead of really being therapeutic with the clients.

Participant: Right.

Interviewer: You've always had papers and documentation to sign to show that what you've been doing is working ...

Participant: Right, to get the evidence, you know, it was all important, and I got that, but I just want to do my work. I just want to do my job, I don't want someone calling me and saying, "You've got to go out and you've got to have this survey done." "You've got to go out and do this, you've got to go back out and have them sign this because it was due yesterday." You know?

Interviewer: Yeah.

Participant: That's not what I want to be doing. I don't want to be sitting, chasing around people to get their signature on a document that they probably don't fully understand.

Interviewer: Right.

Participant: So now, like I said, it's a little bit different, where I'm not as focused on the paperwork, it's more focused on my interventions and my therapeutic process, and really doing what I want to do.

Interviewer: Good! Good.

Participant: Yeah.

Interviewer: It sounds like that organization that you work for sets you up for that, to be able to do therapy.

Participant: Yeah.

Interviewer: OK. Good. Good. Well, kind of moving into more the client care stuff, can you describe for me the types of clients that you work with and client issues that you see in the community mental health setting? And you can, again, pull on that previous experience, as well.

Participant: Like I said, previously I worked with kids who had primarily had ODD, defiance issues, conduct disorders. To put it in my terms, they were the assholes of the society!

Interviewer: OK. Fair enough.

Participant: And I loved some of my kids to death, but they were such jerks sometimes. I'm just, like, oh! I would say they were more like the acting out kids that would cause disruptions in the classroom, cause disruptions in the community, many of them had legal charges.

Interviewer: OK.

Participant: A variety of sorts, some of them more just like parents taking out charges for discipline, with issues at home, some were truancy, some were that they had actually committed a crime.

Interviewer: Wow.

Participant: So it was very much like the outbursts and the, like, I would say externalizing.

Interviewer: OK.

Participant: A lot of the kids that I work with now, I would say, deal with a lot more internalizing. Depression, I get a lot of generalized anxiety. I get a lot of adjustment disorders, where the kid has moved, or the parents are going through a divorce, and the kid was doing pretty well up to that point, and then after whatever happened happened, the kid just fell apart.

Interviewer: OK.

Participant: So, really helping them ... Whether they became self-harming or suicidal, or some of them still have defiance, and acting out and things like that; getting in fights and causing disruptions and things like that. But it's not to the extreme that I worked with before.

Interviewer: OK.

Participant: I guess with out-patient, it's a lower level of care than the in-home stuff.

Interviewer: Right.

Participant: Because the in-home stuff, I was there three days a week for two hours at a time, and now, it's talking once a week for 45 minutes. So it's obviously a less-intense service.

Interviewer: Sure. Mm-hmm.

Participant: And so their problems are probably less intense. But it's a little bit more manageable. And like I said, I work, whereas before, with MST, it's 12 to 17, and now I'm working with 10-year-olds all the way up to 20-year-olds. So, I kind of like being able to have the spectrum of ages.

Interviewer: OK.

Participant: Because it gives me a variety.

Interviewer: Yeah.

Participant: What am I going to do with a 20-year-old that I can't do with a 10-year-old, or what can I do with both of them at the same ... Can I use the same technique in a different way?

Interviewer: So, you get to play around with your interventions a little bit more now, too.

Participant: Yes. Again, I'm not in a box.

Interviewer: Good!

Participant: I pushed that box at MST, just like, I can't just do this. I have to ... I'm a creative person. My undergraduate degree is in art, and that's the way my brain works, is to push the limits.

Interviewer: That's good, it works for you where you are.

Participant: Yes.

Interviewer: I'm kind of looking over the list of things that you had mentioned, that you had checked off. I don't really see a lot of things like trauma, I don't see a lot of ... But I do see PTSD, and it looks like I do see some domestic violence and things like that.

Participant: Yeah, either the kid ... And I was kind of was going off of assessments that I do.

Interviewer: Yeah.

Participant: And people that I work with. Some of the kids have witnessed domestic violence in their home, and one parent or another has left because of that domestic violence.

Interviewer: OK.

Participant: Or, they've been a victim of that domestic violence, in some way or another.

Interviewer: Sure.

Participant: And that was kind of where, it was, like, they had some symptoms of PTSD possibly, but they were still so young, where it was, like, is it really PTSD, or is it just kind of they're still dealing with ... You know, it was not fully ... They didn't have enough criteria to meet a full diagnosis of PTSD.

Interviewer: OK. So you are seeing trauma-related issues.

Participant: Yeah.

Interviewer: It's just when they're so young, it's hard to call it full-on trauma sometimes.

Participant: Right. And then, it's, like ... Yeah, PTSD is so hard sometimes, because there's so many different things. Because I have kids that come in that aren't diagnosed with PTSD, but then when we get ... And I guess in the assessment, they're not going to really divulge a lot of certain information, until you get deeper into therapy. You're, like, aha! So, you were sexually abused as a child! That's where a lot of this is coming from. So, it's probably PTSD.

Interviewer: Yes.

Participant: And you don't really get it out until you really dig down deep into what the matter is.

Interviewer: Yeah. OK.

Participant: Because it's showing up as anxiety and depression and things like that, but they don't really say, "Oh, well, it's just some things that are going on recently," and then you really dig down deep and you realize, OK, you've dealt with some pretty bad stuff ...

Interviewer: Right.

Participant: ... throughout your short little life, because I work with the young.

Interviewer: Yeah, so really, just seeing a lot of hard things for these young people.

Participant: Mm-hmm.

Interviewer: OK.

Participant: Yeah.

Interviewer: How do you think that some of these issues that your clients face impact you, professionally and personally. So, for example ... And you didn't mention this, but I'll give you an example that's come up in a lot of other interviews is, the issue of homelessness, for example, has been an issue that counselors are having difficulty navigating, because obviously when you have a person who is worried about where they're going to live or stay for even the night, it's very difficult to come in and be therapeutic with that person, and you end up doing case management. So, that's just one example. But thinking about the issues that your clients face, how do you see that impacting your ability to work with them?

Participant: I'd say personally, it kind of puts things in perspective, for me. Because when I think things are going really horrible in my life, with personal things, or whatever I'm dealing with, I have a client come in, and it's, like ... And this sounds so horrible, but it makes me feel better. I don't know, because it's, like, I'm able to help someone with a more serious issue, I guess.

Interviewer: Yes.

Participant: You know, it's like, OK, my problems aren't so bad. This kid's dealing with the fact that his mom just died, or they don't have a place to stay, or his mom lost her job and they can't put food on the table. Like, wow! I can go out and buy myself ... You know, kind of puts things into perspective for me. Maybe I shouldn't be crying about my somewhat minor issue.

Interviewer: Right.

Participant: You know, it's perspective. It really does put things in perspective for me.

Interviewer: OK.

Participant: As far as, I have dealt with some of the basic needs type issues. I had a family that I worked with at MST, and I was kind of lucky in a way, because their family dynamic was very interesting, and I think there were five kids in the family, and it was a single mom, and then their cousin ended up moving in with them, and I ended up taking on him as a client. So, with MST, it's at max six months, which is pushing it. It's mostly four months. So I had to work with this family for a really extended period of time, so I really got to know them really well. But when we first started working together, it was at the beginning of last school year, and the mom couldn't afford any school supplies for the kids. So, there's a charity here that basically goes and, all these families can line up, and basically, I think if they're on Medicaid, or if they get any sort of assistance, they basically show evidence of that, and they can go in, because they just don't want anybody coming in ...

Interviewer: Sure.

Participant: ... because it's free school supplies.

Interviewer: Oh, wow!

Participant: I mean, I guess I had never thought about that, because all growing up, I was always able to go and get my school supplies, you know? It was kind

of eye-opening for me. But it was so cool, and I was thinking, oh, maybe they'll have some pencils and, you know, nothing was going to be like this huge thing. They had everything! Basically, the mom got their school supply list from the school, and we just went through the line and we handed it to the volunteers. And they got everything they needed. They got book bags, they got pencil cases. So, it was kind of ... That was one of those moments for me where it was, like, wow!

Interviewer: Yeah.

Participant: I never ... It's one of those things where I would be taking it for granted, but you don't really process, like, whoa, this is difficult for me to afford a box of crayons for my kindergartner.

Interviewer: Right.

Participant: You know, because you go to the store, and a box of crayons is \$2, but you don't think that adds up. And that mom also had to put food on the table.

Interviewer: Right.

Participant: So it's, like, do I put food on the table, or do I buy my kids their school supplies?

Interviewer: Yeah!

Participant: So, it was really cool to work with that family, especially. Because then they lost their house, and they had to move, and we had to get on Craigslist and all these ... You know, I was sitting there doing that kind of stuff with them, of helping them find a new house to live in, and what was going to be affordable for that. So, I've done a lot of that, too.

Interviewer: So it turns into case management sometimes, and just helping them with basic need issues.

Participant: Mm-hmm ...

Interviewer: What you've taken from it is a lot of perspective.

Participant: Yeah. And I usually ... If I go into a family, and they're behavioral issues and things like that, but the basic needs stuff is not met, I focus on the basic needs stuff first, because we need to make sure that your kid's getting fed, and you're getting fed, and you're keeping a roof over your head, and things like that. Because I can't sit there legitimately knowing I'm dealing with behavioral issues, yet you don't know where you're going to get your next meal from.

Interviewer: Right.

Participant: And I don't know if that's just me, or if that's just, like ... But that's ... I mean, I didn't deal with the basic needs stuff all the time, but that's kind of where my focus is. Like, if a family comes in to me and they're going through a bunch of different issues, and then it comes up that they can't afford basic needs, or they're about to lose their house and be homeless, I scrap everything. I'm like, OK, let's figure out where you're going to sleep tonight, or what you're going to eat.

Interviewer: Yeah. Yeah. So you do have to put that on hold.

Participant: Mm-hmm.

Interviewer: I'm kind of wondering about that case management piece. It's not something that I would say we typically get in our master's programs as counselors. So, can you talk a little bit about what you feel like maybe prepared you for that, or how did you figure out case management?

Participant: I know, I felt like it was more of a social work thing. I don't know if social work people in their degrees learn more about that kind of stuff or not, I don't know, because I was in a counseling ...

Interviewer: Right. And they do.

Participant: Yeah. I mean, that's kind of how I equated it, not that that's what social workers do, because we both do both.

Interviewer: Sure.

Participant: But I had no idea. I was, like, I don't know how to navigate this. It was kind of ... Especially in my last job. I would say that's probably my most steady job, because I did contract work before I moved to North Carolina. So here and there, I would do stuff. But my last job was probably my most steady counseling job. And I kind of got thrown into it. And I just had to ask questions, because I worked a lot with court counselors and that, then social workers would come, you know. So it was, like, I just had to figure it out as I went, I guess.

Interviewer: OK.

Participant: I asked questions of my supervisor, and other people who had been working there longer. So that's kind of, I guess, how I figured it out, and learned to navigate.

Interviewer: OK.

Participant: I don't do as much case management in my current job. I did a lot more of it in my last job.

Interviewer: OK. So you don't know that anything really prepared you for it, it was just kind of going through it and asking questions, and just doing it.

Participant: Yeah, I mean honestly, I had never done it before. Because the stuff I did before, I worked in a private practice, I did some contract assessment, some things like that. But it wasn't anything like what I did. Nothing that could compare to what I did.

Interviewer: OK.

Participant: It was a great learning experience!

Interviewer: Yeah, I'm sure!

Participant: And I'm a hands-on learner, that's how I learn, is by doing. And so, it was, like, I'm just going to ask questions and observe, and say, OK. Half the time I call people, and I really don't know what I'm asking. I don't know what I'm calling you about! Figure it out!

Interviewer: OK.

Participant: And I was just, "So, tell me about this family. Can you give me some ... Like, can you fill in, because I know that they're involved with DSS, but I'm not really sure why."

Interviewer: OK. So, not even knowing what questions to ask, just having to start talking and processing it.

Participant: Wing it.

Interviewer: Well, that helps us shift gears a little bit into supervision. It's been thought that counselor development is often facilitated by supervision.

Participant: Mm-hmm. Yeah.

Interviewer: So, in thinking about that, we also know that it's a requirement for the licensure process. Can you describe your supervision, past and present?

Participant: Well, I am still with the same supervisor that I've had since I started my licensure process here, in North Carolina, which is kind of me starting the whole process, anyway.

Interviewer: OK.

Participant: And he is awesome!

Interviewer: OK.

Participant: He's almost like a therapist for me, sometimes. We process through my clients, and any major issues I'm having with clients and things like that, which I feel is a little different now that I'm in a different setting, and I have more clients. Because before, I had four clients, and it was kind of, like, OK, let's go through all four, and OK, that's it, we're done. Bye. You know?

Interviewer: Yeah.

Participant: Now, it's going to be some different things that we're processing through. And also, it's like a personal check-in. You know, he's, like, "How are you ..." Making sure I'm OK. Making sure I'm getting that work life balance down.

Interviewer: OK.

Participant: There's times when I've gone into supervision, and just broken down in tears because I'm under so much stress, and he's, like, OK. And it's kind of like that basic needs thing that I was talking about with my families. He's, like, "OK, we can't deal with your clients' issues until we deal with your issues."

Interviewer: Right. Right.

Participant: And it's, like, whether something happened in the office, or at work, or some sort of stress, you know, he kind of helps me. I'd say the majority of the time, we're going through cases and work-based stuff, and if I have questions about, "How does this work?" "How should I confront this," you know, and there was an issue that I had in my last job where the supervisor was telling me to do one thing, but I had been working with the family and didn't feel that what she was recommending was clinically appropriate.

Interviewer: OK.

Participant: And so, you kind of had this power struggle. And I was asking him, "How do I handle this?"

Interviewer: Yeah.

Participant: I want to respect that she's the supervisor, but at the same time, she's not really listening to what I have to say. And I'm working more intensely with this family.

Interviewer: Right.

Participant: So, things like that, where it's, like, how do I navigate this? How do I navigate confronting someone, or talking to someone professionally about some concerns that I have. And he helped me through the process of leaving my last job.

Interviewer: OK.

Participant: Because that was very nerve-wracking to me. So he helps me in more ways than just going in and doing clinical stuff.

Interviewer: OK.

Participant: It's, like, he's making sure that I am taking care of myself as a counselor, because our jobs can be taxing emotionally.

Interviewer: Sure. So, he emphasizes self-care for you.

Participant: Mm-hmm.

Interviewer: And helps you process not just clinical issues, but also how that impacts you on a personal level?

Participant: Yes.

Interviewer: OK. So, since he's been with you through this whole process, I'm going to make the assumption that he has nothing to do with your organization.

Participant: Well, he was through my last job.

Interviewer: OK.

Participant: They kind of set him up with me, so when I was switching to my new job, I talked to him. I was, like, you know, I worked through ... And I don't want to have to start back all over with a new supervisor.

Interviewer: Yeah.

Participant: So, I was, like, can I continue on with you? And he's, like, "Oh, yeah," he's, like, "We can work out our own contract, and you can just pay me directly." Because my last agency paid for my supervision, this agency doesn't.

Interviewer: OK.

Participant: And so we kind of worked it out. So, he wasn't involved, he wasn't employed, I guess he was contracted.

Interviewer: OK. But he didn't make any of the hiring or firing decisions for you.

Participant: No.

Interviewer: OK. So, your last agency paid for supervision, and this one does not. Do they reimburse you at all?

Participant: As far as I know, no, they don't.

Interviewer: OK.

Participant: But it's kind of ... It was my personal decision just to stay with him.

Interviewer: Yeah.

Participant: I could have found someone here. He's based in Raleigh.

Interviewer: OK.

Participant: I could have found someone here probably cheaper, but it was, like, as I said, I didn't want to have to start over again and go through all that process, where it was just an easier transition to continue with him ...

Interviewer: Sure.

Participant: ... and pay out of pocket, and just ... Because I don't have all that much longer ...

Interviewer: Sure.

Participant: ... in the whole scheme of ... the whole process. I don't have that much longer, so let's just continue on and we'll figure it out as we go.

Interviewer: Right. Yeah. So, your current organization, would they provide a supervisor for you? Was there someone there that would qualify if that's something you wanted?

Participant: I'm sure there is someone, like I said, we have all these contract people, and I'm sure somewhere in there, there's someone that can provide supervision, if I wanted to look for it.

Interviewer: OK. If you wanted it.

Participant: But again, it wouldn't be like it would be provided.

Interviewer: OK.

Participant: I'd still have to pay for it.

Interviewer: You'd still have to pay for it. Yeah, I'm asking, because it seems like a lot of different set-ups there, and a lot of organizations are not paying, or helping out with supervision. And I know that can be a burden; it's expensive, and it all really adds up over the course of 3000 hours. And so, it's a lot.

Participant: Mm-hmm. No, it definitely is, and that was a benefit from the last agency. But there were a lot of cons that kind of drove me out of that job.

Interviewer: OK.

Participant: But yeah, that was one of those things where I was, like, oh, I'm giving this up, it's a great benefit.

Interviewer: Yeah.

Participant: And not a lot of people do cover it. Some people will reimburse you for it. But I'd rather be satisfied with my job than having supervision paid for.

Interviewer: Yes. Big picture. Yeah, OK. All right, so just kind of thinking a little bit ... One last bit about supervision. Can you describe any positive and negative components of supervisor for you in the setting of community mental health?

Participant: Well, for the most part, it's positive. I think for the negative, I would say probably the fact that I have to do my supervision via Skype.

Interviewer: OK.

Participant: Don't get that personal face-to-face in-person interaction, which is good and bad, because it's good because we don't have to worry about getting to each other, or ... It's, like, we just sit down, we do it, you know, I can be at home, wherever. When I worked doing in-home, I was driving all over the

place. There were times where I just took my laptop with me, and I'd be sitting in my car at a parking garage! You know?

Interviewer: Yeah.

Participant: It's, like, OK, here we are. So it's kind of convenient for that, too, where it was, like, I was all over the place.

Interviewer: Yeah. So even though it doesn't feel as though it's as personal at times, there is a convenience factor with that type of supervision.

Participant: Yeah. Which is nice. And it's good that we have that availability ...

Interviewer: Yeah.

Participant: ... to do that. But it's also, as a counselor, I'm a very personal, person to person.

Interviewer: Right.

Participant: I like human interaction.

Interviewer: Absolutely! OK. So, one last question. You know, you talked a little bit at the beginning about self-care and how you deal with stress as a counselor. Can you expand a little bit on that? How do you take care of yourself and manage stress from the work that you do?

Participant: Well, my dog.

Interviewer: OK.

Participant: And she leaves me less stress, even though she's ... We don't use the "O" word, she's a "senior dog."

Interviewer: Ah!

Participant: She'll be 12 in January, so she doesn't really do as much as she used to, she just kind of lays around, but it's just good to have her as a support.

Interviewer: OK.

Participant: Yeah, and I just try, like I said, I try to do things to distance myself, until, I guess, to use my DBT language, "distract the mind."

Interviewer: Sure!

Participant: And those kind of techniques of not sitting around just really over-thinking about it, I guess. I have that little ... Well, not really analytical, but I have that over-analyzing mind, where it's, like, I want to comb through every detail and make sure I'm doing everything I need to do for my client. And sometimes I'll sit there and really think too much about it.

Interviewer: OK.

Participant: Then it's really not ... You know, they're not thinking as much about it. And I'm sitting there going, "Oh, my gosh!" So, you know, I will go hiking, and ... That's kind of why I like living where I live, because there's a lot to do here.

Interviewer: Sure.

Participant: And people are always wanting to come visit!

Interviewer: Right.

Participant: You know? It's, like, I've always got something going on, or something planned. So, I'm not too focused on work. And like I said, three months ago, my last job, that probably would have had a different answer, because

I was constantly having to focus on work, because I was constantly feeling like I had to get something done.

Interviewer: Yeah.

Participant: And I never caught up. Whereas now, I can leave work, and go and go to a concert, or go do whatever I want to do. And I can put my focus on that. I'm doing a training to be a DBT therapist, so I'm working on mindfulness.

Interviewer: OK.

Participant: And really being present, and whatever it is that I'm doing.

Interviewer: Right.

Participant: Whether it's in my session, or whether it's doing my craft work at home, like, building things at home, and doing that kind of stuff. And really being present, and not as I'm doing whatever I'm doing at home, thinking about, "Oh, how am I going to address this issue with my client tomorrow," you know?

Interviewer: Right.

Participant: I just kind of try and be present in the moment and not over-think things too much.

Interviewer: OK. So a lot of self-care strategies for you, that's wonderful!

Participant: Mm-hmm. That's been a process.

Interviewer: Good. Yeah, it is. It is. You get better at it, usually.

Participant: Mm-hmm. Setting limits.

Interviewer: Yes. Limits are very important in our work!

Participant: Mm-hmm .

Interviewer: Well, thank you so much for your help with this!

Participant: Sorry about the technical difficulty!

Interviewer: It happens. It happens! So, we adjusted, and we moved on, and now, we are done.

Participant: Well thank you!

PARTICIPANT 2

Interviewer: Before we get started, do you have any questions about the survey, the questions I sent you or this process?

Participant: I don't think so.

Interviewer: No, Okay. All right, great. We'll just jump right in. I did send you the questions. Hopefully you had a moment or two to look over them today in your ...

Participant: Yes, I looked over them quickly.

Interviewer: ... busy day. Okay. All right. The first thing I just want to get started by is giving you an opportunity to sort of talk about your experiences of being an entry level counselor in community mental health settings. Can you tell me about your job and your role as a counselor right now?

Participant: Sure. My job in the community mental health setting is to do community support team (CST) and I work on a team where all of us on the team are

actually licensed counselors or social workers. We share the therapy and the case management aspects of the job. On one client I might be the case manager and the other person is the therapist and then on the next client switch so that half of my clients are case management clients and half are therapy clients.

Interviewer: Okay, so you are kind of team, teamwork mentality happening.

Participant: Yes.

Interviewer: You are not all case management and you are not all therapy.

Participant: Right.

Interviewer: Kind of mix it up a little bit.

Participant: Yes.

Interviewer: I think I noticed on the survey that you are in a nonprofit organization. Is that right?

Participant: Yes.

Interviewer: It's a private, nonprofit and it looks like you take all kinds of funding sources.

Participant: Yes, pretty much anybody, any individual can pay and they take it.

Interviewer: That's good. You are community support team and before you were part of the community support team were you working somewhere else?

Participant: Yes. I worked at another community agency doing the same thing.

Interviewer: Doing the same thing.

Participant: There I was the team lead, but I did the same thing. My job looked pretty similar.

Interviewer: Okay. I definitely want you to feel free to pull on not just your current job but also the previous role that you had.

Participant: Okay.

Interviewer: I think that team lead experience is probably pretty valuable. You have a lot to think about and share with me about that as well.

Participant: Okay.

Interviewer: Great. I am going to sort of move into a little bit about the survey, the professional quality of life scale that you completed as part of the survey. One of the things that researchers have found is that experience level as well as the setting of counselors might impact our professional quality of life. That is one of the reasons that I included that measurement in the survey. To give us sort of an idea of what entry level counselors are experiencing along the lines of things like burn out, secondary traumatic stress, as well as the positive end of it, compassion satisfaction. You took that. I do have your scores, but you got feedback instantly about that.

Participant: Yes.

Interviewer: I am just wondering if you can describe your experiences taking that survey. Did it bring up anything for you? Any kind of reflection you might offer about that process?

Participant: Because I just started the job that I am currently in and I had a little bit of lag between jobs I felt like my scores were a little bit inaccurate of how I

felt at my previous job. I feel great at the job I have now, but I definitely felt like I didn't have enough hours in the day. I could barely get my work done and didn't feel very supported. I was more likely to have thoughts about how, being discouraged about not being able to do for our clients what we would like to.

Interviewer: The scores for current job seemed a little bit better than they might have been if you had taken this in your previous role?

Participant: Yeah.

Interviewer: Okay. That is a positive thing for you. It means that you are in a good place now. Also, recognizing that you've been there before and you know that it can kind of be a challenge.

Participant: Yeah.

Interviewer: Anything else that you would want to share about that specific experience or process?

Participant: I guess I was just surprised that when I looked at the scale as to what was normal or okay; I fell into that range for everything else. I was like "Oh, I am doing better than I thought I was."

Interviewer: "I'm normal."

Participant: Yeah. Also, realizing that a lot of that has to do with the experience that I have now under my belt that going into the second job was easier than starting the first job. The company that I work for now has a really extensive training and orienting process that I didn't have at all at the previous place.

Interviewer: One of the differences is that you got support and sort of some training at this new organization. The last one you did not?

Participant: Right.

Interviewer: That is helpful. I think we will pull on some of that here as we go. Can you tell me a little bit about why you chose to work in a community health agency? Even going back to the first agency you were referring to.

Participant: During my master's program I had to find my own entry to practicum sites. I had a really hard time finding a site for my practicum. A colleague of mine, someone that I respected as a therapist, suggested that I try this one agency where the person who ran it had been her supervisee a long time ago. She was like, "Talk to him; see if he has anything." I followed up with that and I was pretty much just desperate to get a placement. When he said, "This isn't for everybody, but this is the kind of work we do. We'd love to have you come join us", I jumped at the chance. It turned out that I really love doing community based work.

Interviewer: Awesome.

Participant: I did that all through my practicum and my internship. That is pretty much what I looked for when I graduated; jobs that did the same thing.

Interviewer: You had some positive experience in your internship. It was something you figured out that you liked.

Participant: Yes.

Interviewer: You actively looked for a community based position when you graduated?

Participant: Yes. Yes, I was actually really surprised to hear that the positions I was looking for were often filled by provisionally licensed people because that wasn't the cases at my internship site.

Interviewer: Okay.

Participant: Most the people on the team were fully licensed or had been working in health a long time and they were QP's.

Interviewer: You were surprised that you even had the option to work in these agencies.

Participant: Yeah. Exactly.

Interviewer: Can you say a little more about what you liked about community based work?

Participant: I really liked the client interaction, working with people with psychotic disorders and really severe mental illness. I didn't expect to like that population. I really didn't have any experience with the population, but I found it less frustrating than what people had anticipated that I would find it. That was the thing they were concerned about is that it is a high burn out place to work so, or, population to work with. I really enjoyed it. I found that I was also good at it, which I guess not everybody who likes it is good at it either.

Interviewer: True.

Participant: I followed up with that, wanting to do more of that. I also like the models like CST and ACT where you actually go into people's homes and really help them on a different level than therapy one hour in the office each week.

Interviewer: You like the community based ...

Participant: Yes.

Interviewer: ... you like going out into their homes and seeing that environment piece of it.

Participant: Yeah, and being able to do some of the work around their ... they have things going on in their lives that are related to their mental illness, but therapy is not going to fix it. They are not able to do all the things for themselves that they need done and they really need help with that. It is nice to have that option to be able to help with those things too.

Interviewer: It feels like a stronger way of working with people because you can help them with other things that impact the therapy.

Participant: Yeah.

Interviewer: That is really good to hear that you actually chose it. You looked for it.

Participant: Yes.

Interviewer: Good.

Participant: Yes, I did.

Interviewer: I am actually really glad to hear that. Kind of moving away from that, not too much, in community health organizations one of the things we also know is that you get hired to do therapeutic work, but there are also some

additional responsibilities that tend to get thrown out there. Things like paperwork, documentation, maybe some compliance related things, billing, all those sorts of things that often come, maybe heavier with Medicaid or state funding based billing processes. I am wondering if you can talk to me a little bit about what your experience has been with some of those administrative things.

Participant: I came from a business background so, I was expecting to do paperwork. I knew what I was getting into in that sense as far as having paperwork to do. I didn't really know how to complete the paperwork when I finished my degree. Even though, I had worked in a similar setting as an intern I didn't bill. I worked with clients who were out of authorization units or ...

Interviewer: Right.

Participant: ... didn't have enough to cover what they needed. I would provide therapy to those who were on the team and they were getting services, but not all their needs could be met. I had never had to deal with that billing piece. I was familiar with a person centered plan and other compliance issues. We had staff meetings and I was aware of what was going on and we had team meetings. Of course, I worked with the person centered plan with the clients, but I didn't ever write a whole person centered plan and nobody ever sat me down to show me how to do that. Coming out of my internship I had a lot of skills, but when I actually got into an agency it was like, "Oh, you know all this stuff because you came from a CST background". A lot of things got dropped that I really needed to know. My QP actually taught me most of the things I needed to know about paperwork.

Interviewer: Wow. It sounds like there was an assumption because you had come from that in your internship that you just knew how to do those things.

Participant: Right.

Interviewer: No one really trained you. You had to rely on your QP to teach you how to do some of those basic administrative pieces.

Participant: Yeah.

Interviewer: Wow. How do you feel about the amount of paperwork. You said you knew that there was going to be paperwork. How do you feel about that amount of paperwork associated with community mental health?

Participant: I think initially it seemed like it wasn't that bad, but then when you multiply what you do for one client times multiple clients and they're coming in at different stages. Each week you have somebody that you are doing an intake for and then somebody else is going off the team so, you have to do a discharge and all the paperwork and all that. Fortunately with a CST we can actually bill for those activities whereas an outpatient therapist can't. We can build it into our schedule more so. The agency where I work now, a lot of that ends up being paid for. Not specifically paid, but it kind of falls under we can develop the PCP together.

Interviewer: Right.

Participant: Then, we can bill for that whereas an outpatient therapist can't.

Interviewer: It doesn't feel so heavy because you can actually schedule it into your time.

Participant: Yes, but in the previous agency where I worked we were supposed to actually spend our full... we got four hours a week with the clients, we were supposed to spend that full four hours with the clients. If there was paperwork to do outside of that it was on your own time.

Interviewer: Not too much flexibility before.

Participant: Yeah.

Interviewer: What about the billing piece of it? I have heard from other folks that authorizations are handled differently in different organizations.

Participant: We provide all our clinical evidence for an authorization and put in a lot of the information like the justifications for things, but somebody in our office actually handles inputting it into the system that goes to the MCO.

Interviewer: You have like a Utilization Review person that takes care of those operations?

Participant: Right, exactly. The agency where I am now, they also get the doctor's signature for the medical necessity portion instead of us having to go and get it so, that's a little easier.

Interviewer: That is really nice. It sounds like you have some good resources and some organization behind some of that paperwork.

Participant: It really helps that the people that run the agency where I am now are both full time mental health practitioners in the community and in residential settings for a long time before they started the agency so, they knew what is helpful.

Interviewer: Good. They were able to take that experience and build a better organization for their clinicians.

Participant: Yes. They focus a lot on, one of their core values is that everyone has balance. Not just the clients, but us as staff as well.

Interviewer: Balance?

Participant: Yeah. They really work toward that actively. It is not just like, "Oh, deal with it and hopefully you'll have some balance." It is actually an active part of how the agency functions.

Interviewer: That is great to hear. Very good. I know it sounds like you've got a great situation now. Drawing back on that past experience can you talk a little bit about how the paperwork piece of it, or that administrative burden kind of impacted your ability to work with clients?

Participant: Part of the issue was that I didn't know what I could bill at first at the job that I had before. There were things that I could have been doing to help clients that I wasn't doing because I didn't know that I could do them as part of the treatment, part of the service. Then, when I was spending so much time doing paperwork it just felt like I didn't have enough energy left. At the beginning of the week I felt vastly different than I did by the end of the week because I would be doing notes and paperwork until two or three in the morning and then getting up and seeing clients. At the

beginning of the week I would have slept all weekend and then started my week. Then, as I got toward Friday I'd be dragging and sometimes I couldn't schedule clients in the mornings because I was so tired. I would have to schedule later in the day. It made it pretty challenging. I just felt like I couldn't ... I was tired a lot of the time and so, I probably wasn't at my best when I was trying to listen to clients and help them. Not as creative or alert.

Interviewer: Having to meet all those requirements took a toll on you physically, mentally, you were losing sleep. Staying up very late.

Participant: Yes.

Interviewer: Finishing paperwork.

Participant: It wasn't just me. There were things that my supervisor tried to do to help me get through paperwork faster, but I think he was keeping the same hours so, it wasn't just me. That is just how it was.

Interviewer: oh, goodness. It is just a pattern. That is kind of what everybody was experiencing doing this type of work?

Participant: Yes. Yeah.

Interviewer: Moving now to direct client work that you get to do. Which is why we went into the field after all.

Participant: Yes.

Interviewer: Tell me a little bit about the types of clients that you see, different issues that they bring to your role.

Participant: I probably, because it is community support team, we get some of the most severely mentally ill people. A lot of times people are just out of the hospital and so, there is a lot of crisis intervention going on early on when they start CST with suicidality, some people with homicidal ideation. A lot of people have CPS involvement in their cases. It is not necessarily that there is an abusive situation, but they're homeless or moving a lot and they don't have enough money to feed their kids or clothe them properly so CPS is involved.

Interviewer: Right.

Participant: Then, as far as mental health issues, we pretty much see everything from depression that is really, really severe to bipolar disorder with or without psychotic features, some schizophrenia. A lot of schizoaffective disorder actually on CST. A lot of our clients have co-occurring substance abuse diagnosis. It seems like more and more people, I am finding out, they are not necessarily diagnosed with an anxiety disorder, but when you talk to them their symptoms seem to be more anxiety related than what they had initially reported. Maybe the diagnosis is depression, but they're starting to feel like they can't really go out in the community because they think, they start getting anxious if they get outside because they are worried people are noticing they are depressed or something.

Interviewer: Right. You really do work with the severely mentally ill.

Participant: Yes. We get a lot of co-occurring disorders. ADHD, PTSD, trauma histories, and then on top of whatever other mental illness that they have.

Interviewer: A lot.

Participant: Yeah, usually the people in CST have a lot going on. They are usually also either homeless or in danger of being homeless.

Interviewer: Okay.

Participant: Many of them aren't able to work or have been out of work for a long time because of their symptoms and so, don't have an income or have very limited income and maybe are trying to apply for disability, but don't feel like they can wait out the application process without having a job.

Interviewer: Would you say this is pretty similar to what you experienced in your previous job too, since it was still CST?

Participant: Yeah. Yeah, and during my internship. It is all pretty similar around here for that.

Interviewer: Right. You have not really seen any major shifts in the types of clients. It is very similar criteria that they have to meet.

Participant: I would say that maybe during my internship CST was kind of a step down from ACT, so people who had been on ACT or didn't need ACT could go to CST because it is time limited; six months. They could get services for six months and the hope is that they are stable enough to go back to just a once a week therapy session with management and maybe a therapy group.

Interviewer: Okay.

Participant: It seems like now, because they have made it so hard to get ACT services that there are more people in CST who before would have qualified for ACT, but they're not qualifying now. People who get CST, there a lot of people that will get CST for six months, be denied for an extension and then as soon as the first of the year comes around again they go to another agency to get CST because they are just waiting for the eligibility to open up.

Interviewer: I didn't realize that they had changed the criteria for ACT and it was making it harder for folks to get.

Participant: Yes. They haven't actually changed the criteria for ACT, but the MCOs in our area are a lot stricter about authorizing ACT.

Interviewer: Okay, so, the criteria are the same it is just the authorization seems to get a little more stingy.

Participant: Yeah, exactly. I have heard that it's the same for CST, that people who used to get CST pretty regularly are often being denied of their CST and told that they just have to do outpatient therapy. Then there are a bunch of people in out patient therapy that really need case management, but can't get it.

Interviewer: They can't get it, gosh. Did you move in your prior position? Were you still, you were still in North Carolina. Right?

Participant: Yeah, I was in Raleigh. I am in Durham now, but I didn't physically move.

Interviewer: Is it the same MCO?

Participant: Yeah, it is the same so, I saw that shift happening at my previous job. At least where I work now they seem to have a really good working ship with the MCO. They go to meetings and really advocate for clients that need it. The place where I worked before just didn't have anybody to fill that role. I think that may be part of it. I am seeing that authorizations are more consistently accepted where I work now than they were before. I don't see that there is a huge difference in how they are presented. I think it is partly that there is working relationship and a trust that if this agency says this person needs this then MCO says, "Okay, we'll see what happens."

Interviewer: That is an interesting dynamic that you feel like it was very similar before, but the relationship makes a big difference.

Participant: Yeah. Maybe it is also the agency where I work now has been around for a long time and their outcomes are higher than the average for the area. They may just say, "Oh, Okay if they are saying they meet criteria then, yeah, they must."

Interviewer: That is a positive thing for you then.

Participant: Yeah.

Interviewer: Thinking back to those client issues and how severe that they are and how a high level of need is present for them, even things like homelessness, can you talk a little bit about how that impacts you? Maybe both personally and professionally dealing with those issues day in and day out.

Participant: I'd say probably the hardest one for me is the homelessness because there aren't very many resources in our area and the high definition of homelessness being what it is there are a lot of people that everybody else would consider homeless. They are sleeping on somebody else's couch. A different person every night even, but they are not considered homeless because they are not in the shelter or they are not on a park bench. That is challenging to have to convince people to go some place they don't want to go if they want to get housing. It is not like you go there for one night and now you can get housing. It is going to be months before you get to the top of the waiting list. A lot of people can't deal with the shelters for that long because they've got mental illnesses and other people in the shelter do too but they are not necessarily in treatment and a lot of people in the shelter who just got out of jail and so they have all those issues. It is not a great environment for people to be in any kind of recovery, but that is what there is.

Interviewer: Right.

Participant: I think that is the most frustrating. There just aren't resources. There is not a lot I can do other than say, "Yeah, we'll go fill out these applications", but it is the one thing that people most consistently ask, "Are you going to help me with housing", when they come into CST. It is the thing that they almost always are lacking when they get out of CST at the end of six months because it takes too long.

Interviewer: Homelessness, you would say, is the biggest issue that impacts you professionally because there just aren't the resources available.

Participant: Yeah. It is very hard to make therapeutic progress with someone if they are constantly in a crisis about, "Where am I going to sleep tonight."

Interviewer: Right.

Participant: Which is unpleasant in the summer, but it is really nerve racking in the winter.

Interviewer: Right. Very real concerns about their physical safety.

Participant: Yeah.

Interviewer: What about any other professional impact that you can think of with some of these issues that you face?

Participant: Occasionally with clients that are kind of the revolving door into the crisis center, into the hospital and back out. They barely have a chance to get reconnected with us then another crisis. I find that sometimes the MCOs and the care coordinators, it's like there is an incentive to get rid of that client because it looks bad if we can't fix them. That is not person centered at all. The incentives don't match with what they're saying they want and that can be frustrating too.

Interviewer: Yeah.

Participant: Then, I would say, just personally seeing what people go through has really changed the way that I view the world. Actually in kind of a positive, like I understand how really little things can be really amazingly wonderful for some people and things that we take for granted every day that I don't take for granted as much as I used to. There are lots of times that I forget, but then with clients and see some of the things that can make some of my clients really, really happy are things that I think before I worked in this area I wouldn't have considered as a win.

Interviewer: Right.

Participant: Barely eeking by is not a win, well, for me, now it is, because that's a win for them. It is really important. I'd rather see them happy and healthy and moving forward even if they are homeless than unhappy.

Interviewer: It is actually, personally it has given you some perspective.

Participant: Yes.

Interviewer: That has been a positive for you.

Participant: Yes. It has also just changed the way that I watch television and movies.

Interviewer: Okay.

Participant: Partly it's a self care thing. I deal with so much drama in my work that I don't want to be exposed to it in my entertainment. It is not entertaining anymore.

Interviewer: It is not entertaining anymore so, you then, pay attention to what you're watching on TV.

Participant: Yeah.

Interviewer: If I can validate that for you I am the same way. I don't watch any trauma, no violence. I can't deal with it.

Participant: Exactly. Yeah, I used to be like crime shows and Law and Order, SVU and all of those and I can't watch those anymore.

Interviewer: Too real.

Participant: Yeah.

Interviewer: Moving into that then, I want to talk a little bit about a couple of things. One, what prepared you? What do you feel prepared you for this work? It is really tough work so, if you can talk a little bit about that and then we'll move into self care.

Participant: Sure. As far as preparing me for the work, I think when I started my master's program I had no concept of what I was going to do when I got out. I knew I wanted to help people and I thought mental health was the way that I wanted to do that, but I wasn't really prepared for what the work would actually look like. As I went through the program, especially when I got closer to actually working with clients, I found that the things that initially, I think, drew me into the profession, like people with depression or ADHD or something that, to me, now seems so minor compared to what I deal with on a daily basis was not as compelling to me. It is not that I don't have compassion for people that are dealing with these things. It is just that's not something that, if I had to listen to people talking about that day in and day out, I would get excited about it. I would just kind of get bored eventually. In a way I wanted something that was a little more interesting to me and also a little more challenging. Then, finding out that, through my internship and my practicum, that I was really good at working with some of the most difficult clients to work with. That somehow, naturally, without anybody teaching me, I was able to develop rapport with people who don't easily develop rapport.

Interviewer: Yeah.

Participant: When you have people who have psychotic disorders and a lot of delusional thinking it's very hard to gain trust. You are telling them that things that they know to be true are not true. That is not something that you can do very easily and get very far.

Interviewer: Part of the preparation was just finding out that you were good at it?

Participant: Yeah, and getting a lot of support and validation in my internship. From my internship professors at my university, but also from my internship site. My supervisors were really, really helpful. I still keep in contact with one of them. Also, because I worked on a team, it was like I had four or five supervisors even though I had one that I actually submitted for school as my supervisor. Everyone on my team was willing to give me some guidance or work with me on things. Give me career advice if nothing else.

Interviewer: Having a lot of support and that team mentality really prepared you in your internship, as early as your internship.

Participant: Yeah, then having family and friends around me just saying, "You're going to be really good at this." Hearing the same thing at home that I was hearing at my internship.

Interviewer: Taking that and moving into self care, identifying team and support, family, friends, those kinds of things, what do you do to take care of yourself?

Participant: Work-life balance for me has always been hard and self care. It was actually something that I started focusing on very early in my school career, that I needed to really do better at that. My partner helped me to learn it's okay to take time and do some things. Even if they cost money it's Okay. I wasn't used to that. My family, my parents were self employed so, it is like work as much as you can because you don't have any safety net.

Interviewer: Right.

Participant: I just grew up with that kind of work ethic. It is not the healthiest thing, but it is really unhealthy when you're trying to work with clients who have a lot going on and need you to be at least in the middle of the road if not at the top of your game. I knew that if nothing else, I was so sleep deprived earlier, especially in my internship, that I couldn't actually focus on what people were talking about. I very quickly went, "Okay, I need to keep regular hours and find out ways that I can take care of myself and refresh. I started getting massages every once in a while just to, because I was holding all the stress in my body and not even realizing it. Then, I sing in a choir so, even though it was really hard to keep that up while I was in school it was something, I couldn't give that up because I would be giving up the only thing I did for me. Even though it would have been easier to have not been in the choir while I was in school.

Interviewer: You found, even though, it took some time, making those things a priority and taking the time away really helped you to stay in charge of your own self care.

Participant: Yeah.

Interviewer: Good, it sounds like you are in a good place now.

Participant: Yes. I am very happy.

Interviewer: You've got all kinds of support. Very good. Very good. Kind of shifting gears a little bit here. It has been considered that one of the ways that counselor development is facilitated most is through supervision. We also know it's a requirement for LPCAs. I am wondering if you could just tell me a little bit about your supervision experience, both current and past.

Participant: Interestingly enough I thought I would get more professional development support, professional identity kind of thing from a LPCS. That was actually my least helpful supervision interaction that I had because that person was just too busy, did not have enough time to actually devote to supervision. We had a lot of missed supervision sessions and I was starting to get kind of anxious that I wasn't practicing within the scope of

the law. I actually went out and got my own supervisor. My agency is paying for that one. I found that the supervisor that I connect the best with during my internship, he is a PhD and had specialty in rehabilitation. He used run the rehabilitation unit at the state hospital and has extensive history. I found him to be really supportive and helpful. He looks at everything through the lens of what is positive about this. What is really working here? Even if something is maladaptive he'll point out, "Look how skillful that person is. Look how creative that person is to get that solution to get that need met."

Interviewer: Wow.

Participant: Now, how can we get that same need met with something different. Always looking at whatever the positive is for every single person he interacts with. That, for me, was helpful not only to view clients in that light, but also to get that level of support in my very early days of seeing clients when somebody could have essentially said you should do this, you should do that, you should do this, really torn apart things because it wasn't their style. It probably would have rocked my confidence in myself, but he didn't do any of that. I found that to be really helpful. My current supervisor is a little more specific in breaking things down into how I could do things better and get to the goals that my client is going to need from me more efficiently. She'll talk for a long time and be like, "Okay, I was just trying to say this, but I couldn't figure out how to say it", kind of thing. She's been doing more fine tuning kinds of things with how I actually do the therapy, but also continues to support me in making sure that I understand that I'm good at what I am doing and this is just fine tuning. Also, encouraging me to do other things like take care of myself and spend time with my family.

Interviewer: Yeah.

Participant: Things like that and also modeling that herself. I see this as a really good work/life balance and sets boundaries really thoughtfully. I think that is helpful to me to see that.

Interviewer: The current supervisor that you have, what is her credential?

Participant: She is a PsyD or LCP. She and the first supervisor that I had were both psychologists.

Interviewer: That seems to have been a good fit for you.

Participant: Yeah.

Interviewer: Good.

Participant: I think it helped that the first supervisor was from the rehabilitation background. He had supervised a lot of LPCAs because one of the programs in our state is rehabilitation so, that helps. He wasn't teaching me something that was in a totally different direction even though he came from maybe more of a medical model background he didn't think that way.

Interviewer: That's good. He was not part of the organization. You went and you looked for him.

Participant: He was actually part of the organization where I had my internship.

Interviewer: Okay.

Participant: Yeah, so, I had a supervisor who was on the ACT team when I did my practicum, but he was really busy and so, he suggested that for my internship this other person supervise me. That was the supervisor that I really enjoyed. He kind of like vetted me. I didn't know it was happening at the time, but he met with me and talked to me about things and he decided that he was willing to work with me because I was showing some of the same thought patterns that he wants to see in a new clinician.

Interviewer: Good. All right. In your first job was your supervisor, did he remain your supervisor?

Participant: He didn't because once I graduated he couldn't be my supervisor because he wasn't approved by the board. He did his PhD so long ago that he didn't have the proof to show the board that he had the supervision training. He is very close to retirement age so, he wasn't sure that he was willing to spend forty-five hours of classroom time to get that. He said that it was tempting, there were a couple of people he thought he might like to continue supervising, but he just didn't see how that was going to work. When I got my first job one of the managers where I worked was my supervisor.

Interviewer: All right.

Participant: That one was the one that didn't work out so well because she was just way too busy.

Interviewer: Did that create this need for you then to go out and find another supervisor?

Participant: Yeah. I actually went to somebody that I already knew. We had talked before because I had told her what was going on with having a hard time with my supervising hours. She said, "Well, you know? It is possible that I could supervise you." She has supervised other LPCAs. We thought she'd have to jump through all the hurdles again, but apparently once you are approved by the board you're approved. It went a lot faster for me than it for a friend of mine who's done the same thing. After giving them another month or so and things just weren't getting better I was just like, "Can you just be my back up supervisor?" She was more on paper the supervisor. Most of my hours were coming from my supervisor at my job, but it just felt like I was actually within the law more definitely.

Interviewer: Yeah.

Participant: It wasn't going over forty hours before supervision and not having to worry about coming close because of CST it is not like you can call your clients and say, "I am sorry. I can't see you this week because I haven't had supervision."

Interviewer: Exactly.

Participant: It doesn't work that way.

Interviewer: It doesn't work that way, you're right. You have to keep going. You had kind of a combination in the role of supervision. You had an on site target person who was part of the organization, but then you had a back up supervisor so you knew you were getting support somewhere one way or the other.

Participant: Yeah. I found that my back up supervisor, because I knew her kind of in a different context, and I had known her longer, I felt more comfortable talking about counter transference kind of issues than I did with my supervisor at the agency. We talked a lot more about, "How do we get this person help", it was very case specific.

Interviewer: Right.

Participant: "This person needs this and I don't know how to get that." My outside supervisor was more like how is this affecting me and how do I interact more effectively with this client.

Interviewer: You got plenty of the administrative supervision piece and some clinical supportive ...

Participant: Yes.

Interviewer: Good. Your current supervisor, is this person a part of your organization?

Participant: Yeah. My current supervisor is the one that I got as my back up supervisor at my last job. I am actually going to be shifting to someone at my agency, but that person isn't, he just submitted to be an LPCS so, we're just waiting for the approval. He can't do it for my licensure until he is approved.

Interviewer: Right.

Participant: I have kept the outside supervisor. I'll probably still see her for supervision maybe like once a month because she does DBT specific supervision for me which I am not sure that the one in the agency can do.

Interviewer: Does your agency reimburse you or pay for supervision?

Participant: Not at the moment because they only include it ... I think if I pushed them they would probably say, "Yeah, we can help you out with that because we didn't have somebody who was able to supervise you when you came into the agency."

Interviewer: Okay.

Participant: It's honestly not that big of a deal for me for this very short time. If it were ongoing I would be going down and asking for help.

Interviewer: It can definitely get expensive.

Participant: Yeah.

Interviewer: This new supervisor will be an on-site person. Part of the organization.

Participant: Yes.

Interviewer: Will this person have the ability to evaluate and fire you?

Participant: No, he actually is not at all in the chain of command for my position.

Interviewer: Okay. That may be a positive thing. Kind of wrapping up here a little bit. I am wondering if you could just sort of tell me any positive or negative components of supervision for you specifically in the setting of mental health. Good things, bad things. We've covered a few of them, but ...

- Participant: I think first of all, finding someone in community mental health who has the time to provide really good supervision and to be available not only for once a week, an hour or, group supervision or whatever, but that they're available when I have a question. If something comes up and I need to know, "Hey, is it okay to let this client go? I think he is safe, but I just want another person to kind of walk me through it and make sure that I'm making a good decision here." I don't want to wait three hours for a call back or I don't want to not ever get a phone call. I've had both of those experiences. It is like, "Okay." That is when I pick up the phone and call somebody else that is also a licensed mental health practitioner whether they are my supervisor or not and say, "I just need some guidance." I need that and I am fortunate to have that, but not everybody does. It does make me worry about what do other people do. I am very fortunate to have all my support network of other mental health providers.
- Interviewer: That consultation piece sometimes feels hard to find in the community setting so, you had to reach out and really make that network for yourself.
- Participant: Yeah. I also have a very small private practice. I have like two clients. I felt, when I moved from the agency where I was before to the private practice I actually felt more supported in private practice than I had in the agency because so many people were like, "This is so amazing. How can we help you?" The agency was like, "You're taken care of", but you're not. It was hard. I guess the other piece about supervision that is hard in the community mental health setting, especially CST, is that we have to record sessions or have them observed directly. That is really hard to do when you're meeting in somebody's home or in a public place.
- Interviewer: Yeah.
- Participant: Even if you can record it a lot of times the recording is such a bad quality because there is so much going on in the background that you can't hear what is actually happening in the session.
- Interviewer: Right.
- Participant: When you are working with people that have psychotic disorders it is very hard to get them to trust you to record something. Thankfully it is not 100% of my clients that have psychotic disorders. I can always find someone that I can record. I found that in my previous job I had a really hard time, I had like one, it ended up being down to one client that was willing to let me record. That was really hard to do that and she often has a television on in her living room while we're having session so, it was really hard to decipher what was going on.
- Interviewer: Meeting that requirement was stressful because you really had patients or clients who were like, "No. You cannot record me."
- Participant: Yeah, exactly. I thought about how I feel about being recorded. I don't like that, but I understand the point of it, but the clients don't. Now, what I do is I record my private practice clients because they are fine with it. I just get around it completely.

Interviewer: It sounds like you have had some positives and some negatives.

Participant: Yeah.

Interviewer: Anything else that you would add about your experiences in community mental health?

Participant: I guess I would say that one of the oddest things is the way that our state functions, first of all, for community health, but also the constant shifting and changing and trying to compress everything at the same that time we don't have enough services for the people that are here. It is something that I think about a lot and it frustrates me. If I really start thinking or talking about it then I just get really, really anxious. It is one of those things like I just have to kind of let it go because it is not the kind of thing that I, myself, can change. I can get involved in organizations that work to change that, but it is really frustrating.

Interviewer: It is frustrating. It is hard to change that policy part of it. You are right. They are always shifting it around.

Participant: Mm hm.

Interviewer: It is definitely a tough thing.

Participant: Yeah, and every time you just start to figure out how the system works then they say, "Oh. Now we are going to cut down the number of MCOs by half."

Interviewer: Right. Okay. I really appreciate your time. This has been incredible. You have given me such good information. I am so glad.

PARTICIPANT 3

Interviewer: All right, to begin with, I just want to learn a little bit more about your experience being an entry level counselor specifically in the community mental health setting. If you could tell me about your current job and role in community mental health.

Participant: Okay. I actually started before my license came in, doing some shadowing. As a community based counselor, I work with an organization that has about 18 therapists. We span five counties. I am now exclusively in one county, which is beautiful. I meet clients where they are, so I have done some sessions in parks, at home, on the front porch, on the swing set out back. I do a lot of stuff in the schools.

I also partner with the Head Start. I was able to work with the director to create that relationship with Head Start, so we have some very young kiddos now, as well as their parents. I also work about every other week with a domestic violence shelter in the county. That's kind of where I am.

Interviewer: Great. You are definitely in the community setting.

Participant: Yes.

Interviewer: You are literally in the community a lot of the time. Good. That is wonderful. I think you are going to have some really great information to share about your experiences. Just to kind of back track a bit and go back to the online portion that you completed for this. One of the things that we

have found as researchers is that experience level for counselors as well as the setting of counseling work can impact what we call professional quality of life for a counselor.

That is one reason I had you take the professional quality of life scale, as part of that survey. I'm just wondering if you can talk a little bit about what your experience was like simply completing that survey, thinking if it brought up any thoughts or feelings for you about your work in community mental health.

Participant: You know, I was completing that survey, and for some random reason I had this thought. I'm answering these questions, and I feel very fortunate to not work in the county where I live. There is about a 45-minute commute for me, and I was sitting there thinking. It's just a handful of clients, but if I ran into them at my local grocery store or at the drugstore on the weekend, I'd probably have a lot more of their stuff with me. I think that having that commute between my county and the county that I work in really lets me have that time to put the lid back on things. That's why I think when I took that survey, I was pretty surprised. I don't have their stuff that I'm carrying around with me as much as maybe I thought I did.

Interviewer: Yeah, your scores were good. Your compassion satisfaction level's really high.

Participant: I love what I do.

Interviewer: You love what you do, and your burnout level and your secondary traumatic stress levels were low. That's good news. As you were taking that survey, you were able to see some of the protective factors that help you maintain that, and one of those is being separated from the population.

Participant: Yeah, having that division.

Interviewer: Well, good. Anything else that came up for you while you were taking the survey portion?

Participant: Let's see. There were a lot of questions that were kind of geared toward ... I'm trying to remember. When I work, particularly with my trauma clients, there are some times, and I was noticing I tried when I answered those questions to just answer the question and not reflect on it too long. When I was answering those questions, I was like, hmm. Does this ever bring up any of my stuff? You know, honestly, it does. It's something that I probably would not have focused on had those questions not been asked.

Interviewer: All right, so it did bring up some things for you. It was a time if you had let yourself, that you would have been able to reflect.

Participant: Mm-hmm (affirmative).

Interviewer: Well, good. That's good information. Just so that you know, I don't know if you read it on the little feedback portion, but you can have access to the professional quality of life scale for free if you go to the website, professional quality of life scale. You can use it as a check-in here and there for your own self, and it's completely free and easy to access.

Participant: Nice.

Interviewer: Yeah.

Participant: It was a good check for me.

Interviewer: Good. I'm really glad to hear that it was a good experience to do that and that the results were surprising to you, in a positive way. That's great.

Participant: Yeah.

Interviewer: Kind of moving more into the content of community mental health, a question. Can you tell me a little bit about why you chose to work in community mental health?

Participant: Yes. I did my field experience for my master's degree program in an inpatient institution. It was women and children that lived onsite. It was not as organic as I wanted it to be because their days were planned for them. We had a schedule that started at 7:00 in the morning, and it ended at 8:00 at night. Their days were completely scheduled, and you know, that's just not the way the real world works.

Interviewer: True.

Participant: I was really super excited to be able to get into the real world, so to speak. Not to say that my field experience wasn't a fantastic experience but I think there are some very, very basic tools that we need to survive in this big, bad world. If we don't have those skills or if we have them but we struggle with them, that brings up a lot of stuff, not just for an adult but even more so for the kids that are involved.

Participant: That was one of the big reasons that I really went looking for a community based, so I could meet them on the front porch at their house where they're comfortable. That was one of the big things that drew me there.

Interviewer: Okay, so the idea of working with them in their real lives was really appealing to you.

Participant: Yes. Authentic and genuine.

Interviewer: Authentic and genuine. Anything else that you can think about that pulled you towards community mental health?

Participant: I guess part of this is probably my own energy level. I like to move. I like to go. I like to run, and so it's pretty fun to be able to go from place to place and not be confined to that little 8 by 8 room that I had in my field experience. Being able to be outdoors sometimes. I do some equine therapy, which is fantastic. I do some outdoor stuff and meeting kids at school, that's so much fun. It's a different setting for me which I think keeps me more vibrant. I'm not stuck in one space.

Interviewer: Being able to move around is good for you. It fits for your personality and your energy level, so that was definitely a draw for you. You didn't feel stuck in an office.

Participant: That's right.

Interviewer: Good. I like that. That's a good match then because I do know community mental health is very fast paced and always changing. If you can't keep up, it can be very draining.

Participant: That's right.

Interviewer: It really does fit for you.

Participant: Yeah, it does.

Interviewer: Good. Along with that, I also know that in community based organizations there usually are additional job responsibilities that get doled out, duties along with client care. Things I can identify as paperwork or documentation requirements, maybe the use of technology, or Medicaid things, compliance issues, all kinds of stuff that we deal with when we're in a community mental health organization. I just wonder if you can talk a little about what your experience with those additional responsibilities has been like in the community setting.

Participant: I love feeding the horses, and I really, really don't like all the paperwork. Paperwork is not my favorite part of the job, but it's a necessary part of the job. I get that. I am sitting right here today. I have three treatment plans that I need to write, and I need them done this weekend. From a billing perspective, we have somebody that does our billing for us but we have to feed them the information. The format that they use, it seriously takes about four hours every weekend to put together my billing for the week.

Interviewer: Wow.

Participant: Yeah, so there's a lot of that kind of stuff. Then as far as other ancillary, I have stood at the copy machine making copies of records for subpoenas, that kind of stuff. Honestly, I don't consider that terrible. The billing stuff ... yeah, that's pretty terrible.

Interviewer: Can you describe a little bit more about what that is like for you and maybe the negative parts of that?

Participant: Honestly, I think it's probably me.

Interviewer: I don't know. I'm hearing this is a pretty common theme, so I'm going to reassure you I don't know if it's just you.

Participant: That's good. I felt like it's me. When I come home, I usually see between seven and nine clients every day. Well, that's not entirely true because I do some group work. My group work I count one hour but I might see five kids and write five notes. In those instances, I'm usually home by 7:00 or 8:00 at night, which is just about enough time for me to cram something into my mouth for dinner, and then I'm writing notes until it's bedtime. What that essentially is doing is causing all of this billing stuff to be pushed into what should be my time.

The billing piece is not terrible. It's just a lot of information that they need repeated and repeated and repeated each week, you know? It's difficult to keep track of how many authorized sessions we have left. Our billing is done through *an MCO*, and when we complete a TAR's, a treatment authorization, if you read it, it says three or four weeks. Well, we've been waiting seven and eight weeks.

It's this really big juggle that you have. Do you see the client even though you know that you don't have authorization from *the MCO* for billing? I

usually see them anyway, because I feel like it's not ethical not to. I'm sitting there, usually on Sundays, and I'm trying to figure out, should I bill this? Do I have a session left with this one? You know what I mean?

Interviewer: Yeah.

Participant: It's just a lot of headache.

Interviewer: A lot of headaches, so a lot to keep track of, a lot of repetitive information. You don't have to do the actual billing piece of it, but you have to get it in a format so that it can be billed. It sounds like it really is coming into your personal time, evening and weekend time.

Then on top of that, my next question was going to lean into how do you see that impacting client care. You started to go there a little bit with the authorization. If I don't have the authorization, is it ethical for me to see this person or not see this person?

Participant: I generally err on the side of I'm going to see them. I've gotten to a place with some in my group. I'll bring my group in. If I don't bring one in, they know each other now. If one of them is not there, all the group's very curious, and we kind of back track on our working together because we're concerned about this one missing kid. It's just, to me, become easier to not get paid and keep to that group working intact. You know what I mean? I'm not going to go to their parent and say, "I'm sorry. They're out of sessions, and you have to pay." I'm not doing that. I just rationalize it in my head as it's being a good counselor to keep that group intact. This kiddo is not finished with her treatment plan yet. That kiddo is backsliding, so it's just not worth it.

Interviewer: With that being said, maybe you could tell me a little bit more about your pay structure. Are you a full time employee of the organization? Are you contracted?

Participant: Contracted.

Interviewer: When you make a decision to see someone in spite of having the authorization, you literally are not getting paid for that service.

Participant: Correct.

Interviewer: You're giving away services, essentially.

Participant: Yes. I guess it makes me feel good to be able to do that, to give-back. I don't think about it often. That would kind of put a bad taste in my mouth, and that's not what I want.

Interviewer: Personally you're able to sort of justify that and it makes you feel good about it. If you were to dwell on it ... I'll make you go there for a minute. If you were to dwell on it, do you see that that could get in the way of client care, thinking that I'm not getting paid for this? I'm not going to see this kid.

Participant: I think I would try really hard to keep my stuff out of the room. Do I think over a long period of time that that would have an effect on me? I would be foolish to say no.

Interviewer: Right. Well, that's your paycheck. It does impact you in a very real way. All right. Other than not getting paid for services, it sounds like time is a big issue. Anything else that you would say, those additional responsibilities that sort of eat into client care?

Participant: I'm not a big bag person, but in this role I have different bags for different sets of clients. I have my toy bags. This is something that my supervisor has been working on with me. I am a CBT-minded person, so I am all about some structure, and we're going to break this apart, and it's going to make sense. It's an activity that hones in on our thoughts. I'm a big activities girl, especially with my elementary school. ADHD kids playing basketball with the trashcan rocks.

Stepping back from that and recognizing, it takes a lot of work. I did a self-esteem class last week with 30 kids. We made Hollywood signs. They were fantastic, but you know? It took me three hours to cut out all these silly stars and make sure I have all the right materials, and then I get there. I run out of glue. Stuff. All that stuff does get in the way. My supervisor went, and she said, "What do you think you could have done if you didn't have all the glitter?" She just put it out there, and I was. You know, if I didn't have to put all that work into that, I probably could have seen two more kids.

Interviewer: All right, so sometimes having to administrate these big efforts can get in the way and take away from seeing more clients?

Participant: Or coming back, particularly with our domestic violence shelter clients. When they first come in, they are so raw, and they're so alone. Being able to drop in two days after I had a session with them, just to say hi. Just to do a 15 minute check-in, that would make such a big impact for a client. Not billable, but I don't really care. It would feel good for the client. That's something that I did in the past and I'm finding that I'm not doing that as much.

Interviewer: Yeah, so being able to do those extra things that you know would be good client care, you end up backing away from just because of time and resources. You mentioned glitter, so let me ask about resources. Do you have to pay for glitter, or does your organization pay for glitter?

Participant: No. All the stuff that's in my bag is on me.

Interviewer: Okay, so any creativity in counseling, the toys or extra things comes out of your own pocketbook to make it happen.

Participant: That's right.

Interviewer: There is really a limited access to resources for therapeutic purposes?

Participant: That's right.

Interviewer: All right, so kind of moving along that line. You had started to mention some of the types of clients that you work with. I want to go two places. I want to hear a little bit about the types of clients that you work with and their issues and how those impact you. Thinking also along the lines of

resources, whether it's time resources or glitter, how some of their issues impact your ability to be a counselor or be in that role effectively.

Participant: Something in that made me think of one particular client. She's super, super intriguing to me. She has selective-mutism, which is something that I have zero experience with.

Interviewer: Yeah. It's not super common.

Participant: No. It's not, and she is absolutely super precious, but figuring out the right way to interact with her. I mean, she will answer. Now she will shake her head yes and no to me. Now she will play the blinking game with me. One blink, yes. Two blinks, no. Occasionally, she'll draw something, but she's young enough that she does not write well. That has really taken me to a place, resource-wise, I'm not sure what tools I need. I know I don't have them because the tools that I do have are geared to the Ungame and the I Message game and that kind of stuff. All of the art projects, they're completely interactive, and there's dialogue that happens throughout that. For this one young kiddo, I'm just really struggling. I bought a few books and one of them has a feeling face, and it's got wheels on the top and the bottom for the mouth and the eyes. Everyday, that's how I do a check-in with her. It was really getting creative with what to, and there's no amount of time that I'm going to spend with this young one that is too much. Also, I don't know the resources. Something about what you just said really took me there.

Interviewer: Yeah, that really does impact how you do your job, not just the counseling skill capacity. This is a new issue that you don't have a lot of experience with, but also you're buying the books. You're buying those hands-on resources and tools to be able to work effectively with her. That's a great example. I know you did mention trauma, lots of trauma, things like that. I'm trying to look back. You also noted things like housing and homelessness, lots of stuff that you see.

Participant: Lots of stuff. I think that's what happens when you go out into the community. You get a real feel for what's going on there.

Interviewer: Right. You absolutely do. Thinking about some of those bigger issues, impacting your ability to do therapy, therapeutic work. I know examples like housing and homelessness issues that can be difficult to work with. Who's going to sit down and have a 45 minute therapy session if they don't have a place to live? That's just an example, but can you talk a little more along those lines? How some of those client issues, really severe issues that you've identified can impact your ability to be a counselor?

Participant: Sure. I have three homeless. All three of them are domestic violence situations, and they have separated. They went to a domestic violence shelter, but their time expired there. The extra resources provided by the community to help get them back on their feet, they're just not there yet. There's a backlog, and they're waiting. I've got clients that, I don't really

understand this, but they all have cellphones. That's how we stay in contact with each other.

One of the big things with these three women, these are the ones I'll meet in the park. I have sat behind the restaurant where one of them works to have a session with them. I don't know where I'm going to be when I'm meeting with these clients, short of them sending me a message and saying, "Hey. Can you meet me at blah, blah?"

One of the other things that I tend to do with these women is I tend to bring food. I had some lotion in my car, and last week it was really cold. My hands were really dry, and I put some lotion on and right before I got out of the car to go see this one, I said, "I wonder if she would like some?" I took that lotion in with me instead of doing it in the car and leaving it there. I don't want to say it's a goodwill, but it's almost a goodwill. You know what I mean?

Interviewer: Yeah, so you are having to meet some of those really basic needs before you can talk to them about the larger issues?

Participant: Yeah.

Interviewer: Wow. How do you feel like those impact you personally? You started to go down that line at the beginning. We talked about having that drive, that commute which is really helpful. At the same time, I know that these things do impact us.

Participant: It does. Probably, I'll use the most extreme that I have. I've got this kiddo, and over the summer he experienced a bad trauma. His cousin was jumped by a gang, and he was basically held at gunpoint. It was a terrible event just in writing. Now this kid, I think he's a teenager going on dead. His behaviors have gone completely out of control since that happened. Listening to the principals and the teachers all talk about him, the difference between last year and this year, it's almost like this kid's a different kid. We know that it's routed in that but getting to that. Ooh. There are some days... a couple weeks ago, this kiddo got so mad in session, he threw a chair across the room. I see him at school. It took us some time to get that calmed down a bit, and then I'm not going to let him get by with it. I had to do the call out. "Really? What was that about? Why are you throwing chairs? We're not two. I don't see a two-year-old in here." Just to kind of help him own that. I left out of that school and didn't even realize I was practically running to my car. I needed to get away.

Interviewer: Yeah, well it sounds like kind of a scary situation, realizing that you needed to run to get to your car.

Participant: I needed some space.

Interviewer: Part of how this can impact you is physical safety issues. That's a great example. How often would you say that you feel either uneasy or somewhat unsafe in your work?

Participant: Right. That is an experience that I've never had in my little 8 by 8 office. I knew that if anybody did anything in that office, the person in the office

next door would hear. Meeting clients where they are means that you do kind of put yourself out there. There are some times ... I've got some clients with adult children that I don't know.

I've had one when we were outside at the picnic table. This adult son comes up. He was so mad at his mom's homework. He is totally trying to intimidate me. He's holding a hammer, and he starts flipping the hammer on the picnic table. He wasn't flipping it at me, but he was definitely trying to intimidate me. There are some times where safety is a concern. I guess the approach that I take with it is more of, it's really not about me. I try to let it be with the client. That's his stuff. That's not my stuff, and just kind of go with it.

Interviewer: Yeah, so some self-care there is to say this isn't my stuff. This is theirs. You can put up that boundary between this isn't about me. You've also mentioned for self care, that that drive is important to sort of put the lid back on. I like the use of that. What other kinds of things do you do for self care?

Participant: Being a super active person means I don't know how to find the off button either. Sitting on the couch watching TV or reading a book is not something that I am super good at. I tend to read my Psychology Today's sitting at stoplights.

Interviewer: Oh, goodness.

Participant: I do think that I have a fair number of hobbies. They are active. I kayak. I love hiking. I love jeeping. I love biking. If I can do it outside, I'm going. If I have to be cooped up inside, I love to paint. I try every weekend to do some thing that is purely selfish.

Interviewer: Yeah, so a lot of activity, a lot of creativity. Really just taking care of yourself in those expressive ways. That fits your personality is what it sounds like. You really use that for the positive.

Participant: I do.

Interviewer: That's really great. We've talked about a lot of things, a lot of client issues. Can you tell me, maybe thinking back, what do you think prepared you to do this kind of work as a counselor, this community based work?

Participant: I guess what created the fire is my son's counselor. I had my son in play therapy when he was three years old, and he stayed there for a few years. His therapist looked at me and said ... my son used to have a lot of anger, and I have never hit him. I read the 1-2-3 Magic book, and I found that before I found the counselor. He was like so impressed that I found the 1-2-3 Magic book. I kind of took that and did my interpretation of it, so I would come up with these very creative punishments.

I came in to do the parent check-in with the counselor one day, and my son had had an issue that week. I had him sit down with a poster board. I drew a big circle in the middle of it, and I said, "Write what you feel." He wrote that, and then I said, "Now. I want you to draw bubbles all over this

page, and I want you to put words in them." He created this bubble page. The counselor said, "That's a brilliant idea. I'm stealing it."

Pretty much at that moment, that's where the fire happened for me. I was like, it's time for me to go to school, so I went to school. In terms of preparing me for community-based work, I'm not sure that there is a preparation for it. You either do it or you don't. I think if I was a homebody and if I absolutely loved that 8 by 8 office that I was in with my field experience, that's what I would have gone after.

I wanted something organic. I wanted it natural. I wanted to meet them where they are, and I think that's what made this right.

Interviewer: Yeah, so no real preparation. You can kind of look back to personal experiences that sort of sparked it and got you interested in the field, but as far as community specific work, you don't know what prepared you. You just kind of did it and went with it and found that you like it.

Participant: Yeah. It was almost like I looked at field experiences and said you know what? I like these parts of it and not these parts of it. You know what I mean?

Interviewer: Yeah, so kind of that field experience or internship type experience helped you decide or helped you move into that. A little more specific, I want to ask, because you've given me good information. Thinking about those additional responsibilities like the paperwork, Medicaid billing formats and all of that, do you think that you got preparation to deal with that piece of it?

Participant: In school?

Interviewer: Well, school or anywhere.

Participant: No.

Interviewer: No. Okay.

Participant: No. In my field experience, we were a donor-based program. We didn't file anything. I learned the importance of notes when my internship supervisor said, "Okay. We're not seeing any clients today. We're writing notes." I essentially went through like three spiral bound notebooks of her chicken scratch trying to figure out what to put down for notes because she hadn't done her notes in like three months.

Interviewer: Oh, wow.

Participant: Yeah. That was trial by fire and a practice that I knew that I was never, ever going to do. I'm panicked right now because I have notes from Monday that I haven't written, but that's two days ago. I learned a little bit about what I didn't want to do. In terms of that whole billing debacle, I never had a single assignment in my grad program that said, we're going to do billing this week.

Interviewer: Right, so graduate school doesn't seem to prepare us to do the Medicaid model of documentation at all.

Participant: Yeah.

- Interviewer: Do you feel like you got good training, once you were in your role? Did you get support around that?
- Participant: Yes. The director at our practice is probably the most patient person I have ever met. She will repeat herself time and again. There are some things, and the more therapists in our practice that I interact with, the more I realize we all have parts of us where we are thick-skulled.
Participant, our director, she is super patient and understanding. She will repeat herself again and again. She'll give us some examples. She has sent me her billing sheet before and said, "This is what I do. I'm not saying this is exactly what you need to do." She's very giving of information, which really helps.
- Interviewer: Good. Along that same line, we believe that supervision is one of the ways that we develop as counselors and we can facilitate that. It sounds like you get some supervision around documentation. Can you talk a little bit about your supervision experience? We know it's good. We also know it's a requirement. The state board makes you get supervision, so describe your supervision a little bit to me.
- Participant: I love my supervisor. Is it something that if the state didn't have such strict requirements on what supervisors need to be, I would want my director to be my supervisor. She knows the faculty of the schools that I'm in, and that's something that she doesn't have. Being community based, I think I would have a greater supervision experience if somebody in the community were my supervisor, instead of having that drive, because my supervisor's closer to me.
In terms of benefits of having her as my supervisor, first she is a riot. She's got a lot of the same qualities that I have. I enjoy that she calls me to the carpet and says, "Okay, so..." Like my first quarter, I gave her my hours sheet, and she comes to me, and she says, "Okay, so I absolutely know that you did see this many clients because I don't know how in the world you do it, but I'm really questioning your indirect hours." She challenged me. She said, "So, I bet you probably just at the end of the week go, hmm."
I said, "Yeah, that's pretty much exactly what I do. I know I saw 55 clients. I saw them in 40 hours, but in terms of my indirect hours, Lord knows." She said, "Okay, so here's what I want you to do." She sent me a link for a calendar that is marked every 15 minutes, from 7:00 in the morning until 7:00 at night. I had to attach a sheet to the back of it to log all of my indirect hours, and I ended up with 23.15 for a week. She said okay.
- Interviewer: That's a lot, and you're only allowed to count 40 hours max toward the licensure. I guess I should repeat that differently. I should say, you're only allowed to work 40 hours in a week, so even that is a struggle. It seems as if you can't do your job in 40 hours.

One of the things, though, that you like about your supervisor is that she calls you out on things that you need to work on. It sounds like your personalities are a good fit for each other, but you also mentioned that you wish that your supervisor in some sense was part of the community practice, that that supervisor knew and understood what was going on. I'm assuming your supervisor that counts for your licensure and all of that, is not part of the community mental health setting. This is a completely outside person.

Participant: She's faculty.

Interviewer: She's faculty.

Participant: ... at a university.

Interviewer: All right, but she meets all the requirements set forth by the state, but somehow it feels like something's missing.

Participant: Yes.

Interviewer: That director experience is more hands-on. It's more understood what's going on.

Participant: She knows when I say I was at this particular middle school today, she already knows.

Interviewer: She knows the whole concept of what that means and what you probably walked into.

Participant: Exactly, and with my licensure supervisor, without the context, the issue is not really as present. You know what I mean? Yeah, for those very particular, for that rough kiddo that I just know there is a sweet soul inside of him, it's just how to get it out. When you have all of these administrators inside the school, and they're all trying to set him to fail just because their personalities are that way, it's hard to convey. I guess it's more challenging to convey that whole scenario to somebody that's never been there.

Interviewer: Right, so one of the disadvantages of having that outside supervisor is her not understanding the context. You get good supervision, it sounds like. You really respect your supervisor and feel like you're getting good feedback but that one piece is missing. Now because you have an outside supervisor and you're contract, tell me who pays for your supervision.

Participant: Oh, that would totally be me.

Interviewer: So no reimbursement, no benefit for supervision through the organization?

Participant: No, ma'am.

Interviewer: Is there anyone in your organization that even could supervise you?

Participant: No. There used to be, but she left.

Interviewer: Okay, so it's not even an option. You had no real choice but to find an outside supervisor anyway. All right, so you talked a little bit about some positives. You talked about some negatives. Anything else that you would want to say about kind of the general supervision experience?

Participant: Can I throw one more positive into the supervision pile?

Interviewer: Okay.

Participant: Because my supervisor is faculty at the university, she happens to have access to a lot of resources. Any case that I bring up in our supervision, she is so forthcoming with, "Oh. Let me send you this journal article. Let me send you the wellness wheel, and this and that." Whatever it is, she has something for it. I don't know. I enjoy that freshness.

Interviewer: Maybe even the academic side of it that you get that you wouldn't get with a community based supervisor. She's got access to some of those higher-level resources.

Participant: Yes, you know what? It so totally disappointed me when my log-in for online library left me. I was, "What? It doesn't work any more. I thought I got this for forever."

Interviewer: I understand. Yes.
Well, great. This was a lot of really fantastic information. Thank you so much. I want to just give you an opportunity to sort of sum up or say anything else that you feel would be important to say about entry level counselors in community mental health.

Participant: Hmm. I hope that what you find is that we do take care of ourselves, but I think what you'll find is that we probably fall short.
Can I see it when it's done?

Interviewer: Yeah, sure. Absolutely.

Participant: That would be fantastic.

Interviewer: I'll make a note. That is wonderful. I appreciate that. Here shortly, I will set it up so that you get your Amazon.com gift card for \$15.00 so you can go and buy a resource that you want.

Participant: Thank you.

Interviewer: You're welcome. I thought that was a good incentive because I understand a lot of LPCAs are responsible for their own resources, so I thought that will draw them in.

Participant: It'll be a fun book.

Interviewer: Good, some self-care.

Participant: It's nice to meet you.

Interviewer: Thank you. You too. If you need anything in the future, don't hesitate to reach out.

Participant: Thank you.

Interviewer: Thanks. All right, bye-bye.

Participant: Bye.

PARTICIPANT 4

Interviewer: Make sure we are going here. OK. I sent you the questions for the interview process. That is what I will be working from. Hopefully you had a chance to just kind of look over those so you sort of know what we are

talking about. The first question I have for you, just to get us started, is I would love to learn a little bit about your experiences as a entry level counselor working with community mental health. If you could just tell me about your job. Tell me about your role as a counselor. I think I noticed that you had some past experiences too. Feel free to kind of talk about current, and past.

Participant: OK. Currently I work at a behavioral health agency.

Interviewer: OK.

Participant: It is a dual diagnosis program so I'm working with substance abusers, coupled with mood disorder.

Interviewer: OK.

Participant: I do individual therapy, group therapy, and I do some transition planning.

Interviewer: OK.

Participant: It gets very hectic.

Interviewer: I'm sure.

Participant: I like it, but the re-admissions ... Like the people who have been to our program three or four times and we just opened in April. It can get frustrating working with the substance abuse population.

Interviewer: OK. So you are mood disorders, and substance abuse, so you are kind of doing the dual diagnosis.

Participant: Um hmm. It's interesting.

Interviewer: OK. Yeah, and you see the ...It's stressful. Yeah, it is very stressful. I know we lovingly refer to those folks as frequent flyer's sometimes. OK so you see a lot of the repeat.

Participant: Yes, and the funny thing is we aren't a hospital, but we are an extension of a private hospital in the heart of the city.

Interviewer: OK.

Participant: I was working there, before I got this full time job. So they may have been a new admit to the hospital, but I saw them at the other place five or six times.

Interviewer: Oh my goodness. OK, so you are really getting to know some of the folks in the community there?

Participant: Yeah.

Interviewer: All right. So that's your current role. What is kind of different about your current role, and your past role?

Participant: My past role's, I have been more of like qualified professional, so I have worked in the community doing intensive in-home, working with children. I also worked at another community residential program. So I have worked more with children even before I graduated. So this is really my first experience with all adults.

Interviewer: OK.

Participant: With children, children are easier, because you give them the benefit. You just don't know, you're a child. Adults, I just want to say "really".

Interviewer: So big difference between working with the kids, and working with the adults.

Participant: Right.

Interviewer: There is some stress there.

Participant: Yes.

Interviewer: That is a good segue into my next question. So, one of the things we know as researchers, we have found that the experience level of counselors, along with the setting that counselors are working in, can sort of impact professional quality of life. So, that's of course the scale that you completed. I'm just wondering if you could talk to me a little bit about what your experience was like, taking it? You said it was good to get the results. You liked taking it. Can you give me a little more about that? Thoughts? Feelings? Experiences, with just the survey?

Participant: It really made me think about ... Because usually I can be on auto-pilot, a lot. Just going through the motions. So it made me think about the past month, and how I have allowed the client to affect me. I'm not the greatest at self-care, so it really made me think about my actions and how I allow certain things to affect me.

Interviewer: OK. So it gave you an opportunity to stop and think about how things are impacting you?

Participant: Yeah.

Interviewer: OK. I noticed ... I looked at your scores and I noticed one of the things. I don't know if you kind of remember your scores. One of the things I thought was interesting is you are not scoring for burn out. You are not scoring for secondary traumatic stress, but your compassion satisfaction level was pretty low as well. So, kind of identifying that. That you are OK and you are happy, and you are not traumatized, and you are not burnt out in terms of the work that you are doing. It sounds like you are also struggling maybe with not feeling so satisfied. Maybe not completely satisfied with what you are doing.

Participant: I'm not satisfied where I'm working. My actual role as a therapist, I am satisfied. I like to work with the patients, so on that relationship, yes, I like the interaction. However, the politics that come along with just working in the setting, and not getting the support that I need, or the supervision that I need. I'm not satisfied.

Interviewer: OK, so it's more the environment? The patients that you work with don't bother you so much?

Participant: They don't. I just say, you are here for a reason, you are a substance abuser. I, I know what I'm doing. It's more like the background, that others with me.

Interviewer: OK. Well that's good. That gives us some things to talk about, here in a moment. Before we get into those details of what you do, and how it impacts you. Tell me a little bit about why you chose work in a community mental health agency?

Participant: Well first, I chose the field period, because I like to work for ... I like to help people. That's just me. I like to help people, period. Community, I chose the community because, with me not being licensed, it's difficult for me to get a position in any private setting. Because I'm not ... I can't independently practice as of yet. So, it was ... I was accepted into the community.

Interviewer: OK. So you like the field. You wanted to help people. So that pulled you into the counseling field. Specifically working in community setting, it sounds like it almost wasn't a choice?

Participant: Right. I didn't have one.

Interviewer: So this setting is not something you would have actively looked for, if you would have had your full license, or as a LPCA, if you had been able to work in a different setting?

Participant: Correct.

Interviewer: OK. That's very helpful information. So, one of the things I know, from both experience and the stories of other folks, is that in these types of organizations, we don't just work with our clients. There are usually additional responsibilities that are placed on us. It could be something like paperwork, different types of documentation, working with technology things, Medicaid, insurance, compliance. All kinds of stuff that we, we have to deal with. I'm just wondering what your experience is of those types of additional job responsibilities in community health have been?

Participant: Thankfully, I don't have to deal with insurance. I think I would lose my mind if I did. As far as documentation, my notes are fine, treatment plans are good. I have no issue with the documentations. That's the easiest piece of my job.

Interviewer: OK. That's the easiest piece of your job? OK The documentation. So, sounds like they are doing a pretty good job of letting you work with clients. As opposed to putting a lot of burden on you to do a lot of documentation or filing other paper, administrative things.

Participant: Right. That's because we have a utilization review department, so they deal with all of that. So that kind of takes is off of the therapist.

Interviewer: That's really good. That's really helpful. I know not everybody gets that.

Participant: I know. I'm so thankful.

Interviewer: Yeah, good. You don't have to deal with that. Well tell me a little bit more. I know you are dealing with substance abuse and dual diagnosis. Tell me a little bit more though, in detail, the types of clients, and the types of client issues. That you tend to see in your setting.

Participant: We get a lot of homeless people. Homeless clients who just ... They have thoughts of harming themselves, but really they just want somewhere to lay their head. Then they come to us, and expect us to provide them a home, help them find housing.

Interviewer: Oh wow.

Participant: We deal with that a lot lately. We get a lot of, just depression. Because something triggered their depression. Whether it's the loss of a family member. We have had clients who divorced their spouses, or the children are acting up. We will get a lot of those. Then we will get a lot of substance abuser's who have been abusing substances for the past, like ten or twenty years.

Interviewer: Wow.

Participant: They have been in and out of rehab for those twenty years. So we get a big mix of people.

Interviewer: Wow. OK. So a lot of different things that you see everyday. The homelessness issue. Things like that, that sounds pretty tough. How do you think those kind of things impact you? Professionally and personally, having to hear those things, and see some of those issues that clients have to go through?

Participant: It impacts me professionally because no matter how much therapy you try to give, especially to the homeless client, their main thought right now is, "listen I'm homeless and y'all tell me I can't stay here forever so I really don't care about coping skills. I need to figure out where I'm going right now". So it's difficult appeasing both of those needs. So, telling them we'll try to find placement, but also you need to learn these coping skills so you don't spiral out of control again.

Interviewer: Right.

Participant: It's difficult finding a happy medium. Then personally, it just ... I wish I could save everybody, but you can't, you know. So personally, it is just ... I have to be mindful that you know I can only do what I can do, and I can't save everybody.

Interviewer: OK. So, it's hard to balance that out. You, It sounds like you don't have the resources to help these people with the real issue that brings them in. So that's a struggle. Then personally, you want to help everybody. You want to fix it. You want to save them, and you can't. You have to remind yourself of that?

Participant: Right.

Interviewer: OK. Oh, tough stuff. All right. So kind of moving into a different, a different place here. What do you think prepared you to deal with some of these things that you face as a counselor?

Participant: I wasn't prepared at all.

Interviewer: OK.

Participant: Honestly, I think just going through the motions day by day. I learn something new everyday when I'm at work. So, especially with the population I'm dealing with now. This is my first time dealing with the addition of the substance abuse issues.

Interviewer: OK.

Participant: So, nothing really prepared me for the chaos and confusion that they experience.

Interviewer: OK.

Participant: I just, I pray everyday that God will give, give me strength and help me to be even more effective of a counselor for my client.

Interviewer: OK. It really is pulling on your faith to get you through it. Then just doing it. Doing the experience everyday, and learning. You don't feel prepared.

Participant: Right.

Interviewer: For what you are doing. OK, so you would say in graduate school, this was not something that they covered?

Participant: In graduate school, I can tell you they painted a pretty picture, and they didn't really give me the reality of the situation. Like the reality that LPCA's are not really loved, at this moment. They are trying to get us some love, but we don't have it right now.

Interviewer: You don't have love? Yeah.

Participant: It, it, it's difficult. Our board is difficult. It took me a year and a half to actually get an approved supervisor. Just because everybody I was sitting right ... I had doctor's who said they would be my supervisor, and then the requirements are just crazy.

Interviewer: OK.

Participant: Not friendly.

Interviewer: Not friendly. So, it felt like the requirements of the board, just to get supervision, were too much. So it set you back a year?

Participant: Yeah. I'm actually probably going to be a LCAS before I'm a full LPC. Which is crazy, because I was a LPCA for longer.

Interviewer: OK, and it sounds like that's impacted the type of work that you can do.

Participant: Right.

Interviewer: So not being fully satisfied where you are, knowing you want to do something different, you are stuck.

Participant: Right.

Interviewer: OK, and it doesn't feel like a lot of support from the board.

Participant: Yeah, I don't know what's wrong with them. (laughing)

Interviewer: Yeah. It's a struggle. Well, you said earlier that you may not do the best job of self-care?

Participant: Um Hmm. (affirmative).

Interviewer: What would you say you, how do you handle stress? How do you handle the things you face?

Participant: Ahhh, I either cry, just have a good cry, or I'll eat like cake or a doughnut. Then act like it never happened, and keep moving. I know that is not ... A counselor saying that, that is horrible.

Interviewer: We are people too.

Participant: I don't practice the best self-care. I do make sure I pray and that I do read my Bible, but, as far as you know, relaxation techniques. All the things I teach my clients, I do not do.

Interviewer: OK.

Participant: I know I should.

Interviewer: What get's in your way of doing those things?

Participant: Just frustration, and I allow frustration to ... win I allow the irritation to win, and I just go straight to that slice of cake, and some ice cream, and just lay down and go to sleep.

Interviewer: OK. OK. So right now you feel like you might now have the best coping strategies in place.

Participant: I don't.

Interviewer: And it's frustrating. It's frustrating that you do that, but it's frustrating that, the circumstances that put you in that place.

Participant: Right.

Interviewer: OK. Oh goodness. Yeah it does sound like you're carrying around a lot of stress. A lot of it sound like it's professionally related.

Participant: Yeah.

Interviewer: OK. Well, so I'm so sorry to hear that. But, this is, this is great information. That's LPCA wellness. That's, that's the title of the study. Yeah. Well, you kind of started to hint about this a little bit earlier, but we think that counselor development might be facilitated in a, in a big part by supervision. So, I'm wondering if, we also make it a requirement for LPCA's to have supervision. I know you have had some trouble with getting a supervisor and getting on track with all of that. Can you tell me what your supervision looks like now?

Participant: Um, now? I, when I first started my full time position at the program, a coworker recommended a lady that she use to work with at another place. I've been doing, choosing my LCAS. Yeah, my LCAS supervision, and then my supervisor, she got approved by the LPC board to be a LPCS, so she's been doing both of my licenses for me. Supervision with her is awesome. I learn things. She teaches me things. She just helps me to be a better counselor. Now, this is outside of my job though, and I'm paying her out of pocket.

Interviewer: OK.

Participant: Supervision at my job is non-existent.

Interviewer: Supervision at your job is non-existent.

Participant: I have a manager.

Interviewer: Um hmm. (affirmative)

Participant: She is considered my supervisor, just in, at my job for the board or anything, but it just seems like she's a people pleaser. I do meet with her, at least one day of the week. I'll say to her um, Oh what are some things I need to improve on? Because I'm new to this field and I want to be challenged and told you know, well you did this and you should have probably done this.

Interviewer: Sure.

Participant: I love to learn, and she'll say, oh no you're doing great. You're wonderful. I'm like, no. That's just not good for me. I need to know what to do to improve, and she just doesn't give me anything.

Interviewer: So you're expecting feeding back. You're expecting direction from her, and she doesn't give you that.

Participant: No, she's like, no you're excellent. I'm like, no I can't be excellent. I mean I know I do a good job, but there is always room for improvement.

Interviewer: OK, so you are getting that from your clinical supervisor?

Participant: Yes.

Interviewer: OK. She challenges you, she teaches you things. You said this person is outside of your job environment. So that supervisor has no real connection to your place of employment. Is that right?

Participant: Correct.

Interviewer: OK. So you also have to pay her out of pocket.

Participant: Yep.

Interviewer: Did they offer any kind of reimbursement, or any benefit through your employment?

Participant: They do offer reimbursement, but you get it two months later. So they owe me four hundred dollars right now.

Interviewer: Well. So that creates a bit of a strain financially in order to meet the board requirement, and to meet professional goals, you have to dish out the money.

Participant: Right.

Interviewer: OK. Gotcha. Well that's great information. Can you talk a little bit about any positive, or negative? You've kind of already gone there, but anymore positive or negative components of supervision in this setting? Maybe even pulling on past experiences too?

Participant: I mean the positive thing is I was able to find a supervisor, and I, I am able to grow more and more as a counselor each time I work with her. On the negative side to it, is that it is expensive, and you don't really, the pay ... your income does not really increase until you are fully licensed. Like that's when you really start making the good money. So as a provisional licensed person, it's like I have to go broke before I can make money. Because I'm paying fifty dollars out. Basically two hundred dollars a month just for supervision. Then I have to pay for training to go towards my license as well. Which that is like eighty five to a hundred hours per six CEU.

Interviewer: Wow.

Participant: Then you have to have like, I think it's forty for the LPC board, and more for the LCAS board.

Interviewer: So, it's quite a, a lot that you have to complete. A lot of hoops to jump through to get to where you want to go.

Participant: Yes.

Interviewer: OK. Yeah, um, is there anything else that you would want researchers, or people to know about the experiences of entry level counselor's, going into this setting?

Participant: Um, yes. It's just a struggle to even be entry level. To even get that first job that's going to say, oh you know what? I know you're just getting out of school, so I will give you a chance. A lot of places, they want you to have experience, but they don't count your internship as experience. We're like, well we just graduated. Don't expect us to have experience.

Interviewer: Right.

Participant: So that's like the biggest issue I have coming out of school. Then of course, the chaos with the board.

Interviewer: A lot, a lot of board issues.

Participant: OK, I really appreciate your help. I just kind of looking over the questions. Make sure I got information from you that I needed. Anything else that you, either have a question about, or would add?

Participant: No, I think that's basically it. I went to a good school. Especially for a LPCA and counseling graduate school. I know they have to sell their program, but they should also tell students the reality of what they are walking out into when they graduate. Just so they know and they are not shocked when they walk out there, like, what? What do you mean?

Interviewer: Yeah. So you would have liked some reality, instead of the pretty picture.

Participant: Right. I would do right by telling them that, yeah they do prefer PLCSWs versus LPCA's. They do prefer MSW's versus master's in counseling. So your degree is not always the most marketable.

Interviewer: Oh. Just kind of a follow up question. Do you feel like your training was more oriented towards a private practice setting?

Participant: Um, yeah.

Interviewer: Yeah?

Participant: Yeah. I agree, I would say that.

Interviewer: OK, so some of the community mental health pieces, you didn't ...

Participant: I think they should have offered some discharge training classes, or case management classes.

Interviewer: Case management?

Participant: A lot of counseling education students do go into that social work role, but they don't have that education of, you know, case management helping their clients outside of therapy.

Interviewer: Yeah. I can relate to that experience.

Participant: Um hmm. (affirmative)

Interviewer: Well I really appreciate it. Thank you so much for taking time out. I will email you, here shortly, your Amazon gift card. You do get a fifteen-dollar Amazon gift card, and that will come to your email.

Participant: OK. Thank you.

Interviewer: You're very welcome. Thank you for helping out with this.

Participant: No problem. It's very nice meeting you.

Interviewer: You too. All right. Well, you take care of yourself.

Participant: I will.

Interviewer: OK.

Participant: Bye.

Interviewer: Bye.

PARTICIPANT 5

Interviewer: Okay, I think we're good.

Participant: All right, great.

Interviewer: Good, all right. Thank you so much for doing this. I really appreciate it.

Participant: No, I am so happy that you're doing it. I feel like therapists in community mental health, it's like we're so ignored. So I appreciate it.

Interviewer: Yes, absolutely. That is exactly why I'm doing this. I've been right where you are and I feel like it's super important that we give newer counselors a voice. It's hard work.

Participant: It is. I was excited when I saw your email come through. I was like, "Yes, somebody really cares!" We have to say it.

Interviewer: I'm excited about this study too. I'm hopeful I'll get some good information and be able to publish it and get our voices out there.

Participant: Definitely.

Interviewer: Well, I don't want to keep you. I know your time is valuable so let me get started here.

Participant: Okay.

Interviewer: I sent you a couple of things. One, you did the online survey piece of this, so thank you. The other thing I sent you was the interview questions. Did you get those?

Participant: I did, yes, and I reviewed them.

Interviewer: Good, okay. I didn't expect you to have any kind of set answers for that. I just wanted to give you an opportunity to know where we were going.

Participant: Okay.

Interviewer: Let me kind of go ahead and get started here. I want to learn about your experiences as an entry-level counselor in community mental health. Can you tell me a little bit about your specific job and what your role is as a counselor in community mental health?

Participant: Sure, my main role was, and I kind of still struggle with the title of it, is an intensive in-home team lead. I also do outpatient therapy for individuals who do not receive those enhanced services.

Interviewer: Okay, yes.

Participant: Do you want me to elaborate?

Interviewer: Well okay, so you're an intensive in-home team lead. That's your primary role. You're also doing ...

Participant: That ... Okay, sorry.

Interviewer: I think we have a delay going.

Participant: Yeah, that's my primary role and I always try to step away from it, but it seems like I always get pushed back into it.

Interviewer: Okay. You always get pushed back into that team lead position?

Participant: Right.

Interviewer: Okay. As a team lead, you are an LPCA.

Participant: That's right.

Interviewer: That means that you're making pretty heavy, critical decisions for the team that supports these families.

Participant: That's right.

Interviewer: I'm excited to hear your experiences about this.

Participant: Okay.

Interviewer: Good. Moving into the next section here, one of the things we know as researchers is that the experience level for counselors, along with the setting that we work in can impact our professional quality of life, kind of how happy we are as professionals. You completed, as part of the survey, the professional quality of life scale. You got your scores back from that. I'm wondering if you could just tell me a little bit about what that experience was for you, just answering those questions, having that time to reflect on your professional quality of life.

Participant: Right. I think that the answers, if I can remember them correctly, they surprised me a little bit. I know one was about trauma, I think vicarious trauma. I can't remember what the other two were about because I took it over the weekend, but I thought I would score a little bit higher on two of the scales.

Interviewer: Okay.

Participant: I think it was average.

Interviewer: It was average. Okay, so the scales are compassion satisfaction, which is more of the positive scale there, and then you've got burn out and you've got secondary traumatic stress.

Participant: Okay.

Interviewer: Looking at your scores, you were pretty average on everything. What that tells me is that you're not traumatized really, and that you're not fully burnt out, but that you're sort of wavering a little bit on how satisfied you are with what you do.

Participant: Yes, that's me.

Interviewer: Okay, so that fits for you?

Participant: Yes, it does.

Interviewer: Can you talk a little bit about maybe some other things that this brought up for you, having to reflect, having to answer those questions?

Participant: It really made me have to dig deep into how I felt about the field. I noticed I answered somewhat a lot.

Interviewer: Okay.

Participant: I was like oh, that's not good, but that's how I really felt. It also made me realize how in most cases, I am able to leave my work at the office. I'm happy about that because that's something that I feel like I have struggled with.

Interviewer: Okay.

Participant: I'm surprised, like the compassion, what did you call it, compassion ...

Interviewer: Compassion satisfaction.

Participant: Satisfaction, okay. I thought maybe I would score a little higher or lower, I don't know which way it would go on that.

Interviewer: That's a positive scale. You were surprised?

Participant: I was surprised, yes.

Interviewer: Okay. This might be a good opportunity then for you to process some of those things that came up for you while you were taking that scale. Let's move into the next phase of this. Can you tell me a little bit about why you chose to work in community mental health?

Participant: Well, that's two parts. I chose to go into mental health because I feel like I am the epitome of a wounded healer, which is why I chose therapy to begin with. Now, I didn't know anything about community mental health when I graduated. I kind of fell into it and never heard of intensive in-home. I interned at the agency I work at now, so it was just something I fell into and so I wouldn't say I chose it.

Interviewer: Okay, you just fell into it.

Participant: Yes.

Interviewer: Can you elaborate maybe on why you took the job where you are?

Participant: Well, like I said, I interned there and finding an internship was really hard. The internship site was really difficult and I had to stay in school another semester simply because I had so much difficulty finding that. It was just about the ease of it because they hired me the day my internship was over. I had a job waiting. I needed the money so I just went ahead and did it.

Interviewer: Yeah, it was a job, it was there for you.

Participant: Right, yes.

Interviewer: It wasn't necessarily this really thought out choice. It was there.

Participant: Right, exactly.

Interviewer: Part of that job I'm guessing is you get a salary, you get benefits, you get ...

Participant: No.

Interviewer: No benefits?

Participant: No to either one. I don't get a salary and I don't get benefits.

Interviewer: You don't?

Participant: No.

Interviewer: Okay.

Participant: Would you like me to elaborate on that?

Interviewer: Yes, please.

Participant: What I find overall, at least in this area, because I've talked to other friends in community mental health agencies, is that we are paid on a per-contact basis. When we see a client, we get paid for seeing that client. If we have them booked and they don't show, we don't get paid for that. There is no salary. We're always trying to get people in our chair.

Interviewer: Wow, okay. I'm trying to remember what funding sources you identified that you guys see; Medicaid, private health insurance, and self-pay, is that right?

Participant: That's right.

Interviewer: Would you say that one is heavier than the other?

Participant: I would say Medicaid is the heaviest.

Interviewer: Okay.

Participant: Going back, I told a half-truth. We just started having an option for benefits about a year ago, and I've been there, including the internship, about 3 years; but I can't afford them so I don't get them.

Interviewer: Okay. What about supervision or anything else? Is that included in your employment?

Participant: Yeah, supervision is free, thankfully.

Interviewer: Okay, good. So you're getting at least some kind of benefit somewhere.

Participant: Yes.

Interviewer: Good. Okay. It wasn't really a choice. You fell into it. It was a job. Now that I know you don't get salary or benefits, tell me about this part of your job. I know that in community mental health organizations, there are a lot of times additional responsibilities that are required or expected in addition to client care, so things like paperwork, different types of documentation, maybe working with technology, maybe billing pieces or compliance, just a lot of things that make the organization go. Can you tell me a little bit about your experiences with those types of things and what's that been like for you since starting in community mental health?

Participant: The paperwork is atrocious. I don't have anything to compare it to really, because I've only done this, but I know it's bad. We are, I guess, state-mandated to do so much paperwork, person-centered plans, treatment plans. If we're looking for a higher level of care that is advanced paperwork, it seems like we do more paperwork than direct care sometimes, which is why I specified with you. Okay, are we talking about direct-care hours or overall?

Interviewer: Right.

Participant: The good thing about my agency is that they have provided someone to take care of all the authorization stuff for us.

Interviewer: Okay.

Participant: We do the paperwork, we send it over to this particular person and then they take care of submitting it to the MCO. We don't have to worry about that part which is helpful.

Interviewer: That is helpful. Now, when you are responsible for doing the paperwork, are you given additional time? Is that tacked on to just it's an expectation and you don't get compensated for that in addition?

Participant: It depends because I do intensive in-home and we work in teams.

Interviewer: Right.

Participant: If the service is billable, like there's some paperwork that's a billable service and we can bill for that. There's some paperwork that's not that's still required to be done. It just depends on if the state says that's a billable service or not. So, person-centered planning, as far as I know, it seems like they change them all the time, that is a billable service. I don't know, there's some other stuff that we can't really bill for, and I know when I do outpatient therapy apart from intensive in-home, I can't bill for any of that paperwork.

Interviewer: Okay.

Participant: I don't get compensated at all for it.

Interviewer: Still a pretty heavy burden with paperwork.

Participant: Right, yes.

Interviewer: Pretty fortunate though that you have someone who's doing the authorization so that's good to hear.

Participant: Yes.

Interviewer: I think I'm hearing that as a trend for community mental health these days. I'm happy to hear that moving forward.

Participant: Yeah.

Interviewer: Can you tell me maybe just a little bit about how you see all of that administrative stuff that has to get done impacting your ability to work with your clients?

Participant: Most of my day is spent on administrative duties recently. For example, I saw one client today. I had all meetings and random paperwork. My agency is also going through some serious changes so I think is also part of it. I don't always really get much time in with clients which really has reduced how quickly I've been getting my hours to drop my A as they call it.

Interviewer: Okay, yeah.

Participant: To be honest with you, sometimes I kind of dread if I have to do a whole bunch of extra paperwork that I know is just going to bog me down and that I know I'm not going to get paid for. I'm like oh, I feel really unmotivated to do it and that's honest, but that's about it.

Interviewer: Okay, yeah, but you do see the paperwork as getting in the way.

Participant: Yeah, it definitely gets in the way, and the notes, oh my God. I forgot about that. We're required to do our notes within 24 hours, so that really can get in the way of seeing clients, especially emergency, because with intensive in-home you get a lot of crises and emergencies. Sometimes it's a matter of do I respond to this crisis, or do I do my notes or other paperwork I have to do? Sometimes I feel a little conflicted there.

Interviewer: Wow, so sometimes there's even pressure to get the note done before you care for the client who is in a crisis.

Participant: Well, the agency would never say that.

Interviewer: You're saying that.

Participant: Yeah, they have these punitive measures in place where your pay will significantly drop if you don't get it in on time. We already, in my opinion, are low paid. Now granted, I will say this, you're allowed to go to them and say hey, I had this emergency. Will you waive my 24-hour? Most of the time they will say yes.

Interviewer: Okay.

Participant: I will give them that, they will say yes most of the time.

Interviewer: Oh. Okay. Let's move forward a little bit here. Can you tell me more about the types of clients and client issues that you work with, specifically with the intensive in-home stuff. I do know what you're talking about, so for the sake of this study I'll probably ask for some more details, but can you just kind of describe the type of clients that you work with and some of the issues you see?

Participant: Yes. Of course for intensive in-home, they have to have some pretty severe behaviors. Typically I work with a lot of defiant children, children who are noncompliant, children who have been traumatized.

Interviewer: Okay.

Participant: As far as demographically speaking, a lot of our children are young, black children and they have single parent households. A lot of them live in not the best neighborhoods. They don't go to the best schools. Overall, they have pretty shady environments, which makes it kind of difficult to work with them too. Basically, ODD is the biggest thing we do, and disruptive behavior. Well, of course, this is all DSM-IV stuff.

Interviewer: Right.

Participant: The disruptive behavior disorder, a lot of ADHD.

Interviewer: Okay.

Participant: I think that's the biggest ones.

Interviewer: Mostly, children are the identified clients for intensive in-home, but that means then that you're working with the families?

Participant: Right, yes.

Interviewer: Okay, so on top of that, the childhood issues. Can you talk a little bit about what you're seeing with the families?

Participant: Yes. I'm seeing a lot of the families are single parent households. A lot of them are doubled up, many of them are doubled up so it's like two families in one home. They're either living with grandma or friends who let them crash because homelessness is a big issue.

Interviewer: Okay.

Participant: Parents, it's difficult to get buy-in from them at times. They don't understand that this is a family service, even though we try to explain it as best as we can. It's more like just fix my child. They're the problem. That can be difficult, but that's part of it and that's something that we fight that uphill battle to get them engaged as well.

Interviewer: Okay.

Participant: Unemployment is a big one as well. A lot of the parents are unemployed or underemployed and I think that's about it.

Interviewer: Okay, so a lot of heavy issues and a lot of behavioral issues for the children, but a lot of I guess we would maybe say lifestyle. I'm not sure what the category is, homelessness, unemployment, financial kinds of issues.

Participant: Right.

Interviewer: Okay. How do you think that those types of issues that your clients face are impacting you, both professionally and personally?

Participant: I think from the time I was an intern, it really hit me that the issues that you have to have in order to get intensive in-home, those are heavy issues. It's unfortunate that it's new therapists dealing with these issues because we are fresh out of grad school. Grad school does not teach you, at least my grad school didn't teach me anything about dealing with these kinds of issues. It's like go figure it out when they need expert work almost. It makes you feel, or it leads you to feel very overwhelmed, like you're drowning, you don't know where to turn. You feel sometimes incompetent because it's like what am I supposed to do here?

Interviewer: Yeah.

Participant: Then when you feel that way professionally, that can lead to personal concerns with self-esteem, my own feeling of depression or anxiety and things like that.

Interviewer: It definitely does impact you?

Participant: Yeah.

Interviewer: You brought up, you said competency.

Participant: Yeah.

Interviewer: I like what you said. I would agree with you that we do tend to put our least experienced counselors in these settings where there are pretty severe issues.

Participant: Yeah, and you know what, I've realized that I think when people are fully licensed, they run. That's what I've experienced. They're like, goodbye. I'm going into private practice now, or I can do something else. It's the two-fold thing. There has to be something, some type of incentive to stay and do this kind of hard work, and there just isn't one.

Interviewer: Yeah, you are so right. You started to kind of go into this. My next question is, what do you think prepared you to deal with this type of work as a counselor?

Participant: I don't know what can prepare you. I was lucky enough to do my internship there, which I was able to get some insight. I don't know if I made the right choice. I mean I have seen interns ... My agency is really good at picking up interns as employees, but I have seen interns say this is not for me. I'm going to leave. Either I'm going to leave this field, or not go into the field, or maybe just try to find therapy work in a different setting.

Interviewer: Okay.

Participant: I think an internship at community mental health agencies would be beneficial to know exactly what you're getting into. Other than that, I can't think of anything else that I would comment on. Maybe shadowing, knowing somebody. I don't really know of anything that can prepare you.

Interviewer: Yeah, so you don't feel in general prepared. You mentioned earlier that you didn't feel like graduate school prepared you for this.

Participant: No, not at all and I think when I talk to the other therapists in the agency, they feel the exactly same way. The graduate school did not prepare us for this at all. They gave great skills, but not for this.

Interviewer: Okay. You had no idea what was coming unless you had gone through your internship, you would not have known what to expect with community mental health?

Participant: Right.

Interviewer: Okay. Thank you. Moving into more of a personal area here. How do you tend to deal with stress or self-care needs?

Participant: For me, I would probably say my biggest area of stress management is I have a really strong spirituality base. That's the biggest thing that's kept me going. It's a more minor thing, but I try to work out a couple times a week, and that's it, and I talk to other co-workers, other therapists. I can't talk to my friends. They don't get it, but I'll talk to my co-workers.

Interviewer: Friends don't understand, but you can kind of find that support in your co-worker.

Participant: Yes, absolutely.

Interviewer: Otherwise, you say that your faith, your spirituality, that's a big strength for you. Then trying to work out?

Participant: Yes. Oh, and I'm an avid reader. I try to read every night to try to relax.

Interviewer: Okay, good. You have some things you do to try to take care of yourself. That's good.

Participant: Yes, I do.

Interviewer: All right. Kind of moving on here with the supervision piece. One of the things that we have considered pretty strongly in the field is we think that counselor development might be pretty strongly facilitated by supervision. We know that it's a requirement for LPCAs. Can you tell me a little bit about what your supervision experience is like?

Participant: Yes. My supervisor is also my clinical director. I think she's great. She's very person-centered as I am as well. She leans in that direction. She's very big on those things. I've noticed not everybody is big on those type skills. The only thing is, I think sometimes that she may be supervising too many people, or maybe she just has too many other responsibilities as well. Like we were scheduled to meet yesterday and she had to cancel, but at the same time on the flipside of that, she's more than willing to stop whatever she's doing if she can to do an impromptu supervision, so it kind of balances out a little bit.

Interviewer: Okay, so if you have an issue that comes up, she's usually there, she's available, but sometimes she just gets so busy that she has to shift things around.

Participant: Right.

Interviewer: Okay. You said she's your clinical director also, so she's in-house, she's part of your organization. She also, I'm guessing, makes decisions about your employment there?

Participant: Oh yeah, definitely, right.

Interviewer: Considering some of that, can you talk a little bit about positive and negative component, the supervision for you there in that type of setting?

Participant: Okay, that's a good one. Negative, I remember in the early summer, I could not take intensive in-home anymore. I was having breakdowns, crying spells and during supervision, I had one of those crying spells. Afterwards, I was like, oh my gosh. What if she feels like I'm not capable enough to do this job? What if she fires me? Just those types of thoughts. I think having a supervisor who's also your employer, you can't really be completely authentic and honest about what you're experiencing. I mean I got through that and I'm still employed, but it was definitely a concern that you can have.

Interviewer: Yeah, okay. Then maybe I heard one of the advantages is that she's there if you have something that comes up.

Participant: She's there, yeah, and it's free ...

Interviewer: It's free.

Participant: ... because she's my employer. I know it can be very expensive.

Interviewer: Yes, it can be very expensive for sure. That's one of the advantages too, is that they include that for you.

Participant: Yes.

Interviewer: Well good. Anything else you can think of that you would want people to know about your experiences in community mental health?

Participant: I would say that the current climate ... Okay, so I graduated almost two years ago. I started off as a QP while I was waiting for my license to come through. We have had three MCOs in those two years. I think that just from what I've experienced, the stuff that comes down from that is so anxiety provoking, the audits are ridiculous. It's very punitive, and it almost feels like a sense of instability to a certain degree when most of your clientele are Medicaid funded because their rules and regulations are so out of control.

Interviewer: Okay, so just kind of the overall climate and seeing so much instability creates some anxiety.

Participant: It does and as a matter of fact, my agency last week, we just found out that we had lost our contract with the MCO and therefore, the way we exist now, we're going to cease to exist in that way.

Interviewer: Wow.

Participant: This has been hanging over our heads for over a year. Working in that kind of environment, it's really difficult to deal with that and then still go see clients and work through what they have going on, but that's a stressor for any therapist at all.

Interviewer: Well yeah, I think you're right. It's a tough environment. I really appreciate you taking the time to answer these questions. I think what you have to say is really valuable and I think that some of your experiences definitely mirror what I went through early in my career too. I'd like to say it gets better, but it's a tough road for sure.

Participant: Yes it is.

Interviewer: Okay. Well, thank you so much. I really do appreciate it. If you don't have anything else, I will let you get back to your life, because I know ...

Participant: Okay.

Interviewer: It's a busy life. You can expect your Amazon.com gift card to come to you through email.

Participant: Oh okay, cool.

Interviewer: Yep, you'll get a \$15 gift card after this is done. I'll set it up so that it'll get sent out to you. It's just a little perk, yes, because I do appreciate it.

Participant: Okay, thank you. I appreciate that.

Interviewer: Okay, thank you so much for your time.

Participant: All right, you have a good night.

Interviewer: Thanks, you too.

Participant: Bye-bye.

Interviewer: Bye-bye.

PARTICIPANT 6

Interviewer: I know your time is valuable so I will get started. Did you get a chance to look over the questions that I sent?

Participant: Yes.

Interviewer: Okay, good, so you're kind of prepared. You know what I'm about to ask you. That's good. I did take a quick look this morning at your score and then the survey information. Did you have any questions about the survey that you did?

Participant: I don't think so.

Interviewer: Okay. Just to sort of get us started if you could talk a little bit about your experiences in general being an entry-level counselor in a community mental health agency. Tell me a little bit about your job and what your role is here in this community mental health setting.

Participant: Here I split my time between being an early childhood mental health consultant and an outpatient therapist. For 20 hours a week, I do the mental health consultation and what that requires is me to go to different childcare centers and work more so with the teachers on strategies of how they can better manage behaviors and support social, emotional competence, and help connect them to resources in the community.

Then in the afternoons I see clients here, pretty much exclusively children and families.

Interviewer: Children and families.

Participant: I've got my child hat on today.

Interviewer: Your focus is children. Then the family piece comes naturally because children have family. All right, and so you split your time between outpatient and then I like this consultant in the schools. Is it just kind of childcare or is the school system?

Participant: It's been just private daycare so far but we just got some funding and permission for the public school system so pretty soon I'll be doing that too.

Interviewer: That's really neat.

Participant: Yeah, it's a contract position and so it's through this agency as well, but ... I mean, the funding's not through here, but the contract is.

Interviewer: Because I know this agency has other sort of branches in different locations, is that limited to this county?

Participant: Yep. In another county they have a contract with Head Start. They do similar work, but this is a different grant.

Interviewer: That's really neat. I hadn't heard about that so that's a really neat thing that they're doing.

Participant: They've been doing it I guess for like a year and a half now.

Interviewer: It's really fun for me to get to hear some of the things that are going on in the community mental health that I hadn't known about.

Participant: It's nice for me because they've sent me to two different trainings so I've done the triple P, positive parenting, and then something called Incredible Years, so that's good to have evidence-based practices.

Interviewer: And that's specific for teachers?

Participant: Mm-hmm.

Interviewer: Okay.

Participant: I haven't done the parenting one.

Interviewer: You haven't done the parenting one.

Participant: Hoping to do the infant and toddler one next.

Interviewer: People that I know that have done it really love it.

Participant: Yeah. I've heard good things.

Interviewer: Good.

Participant: That's hard to find.

Interviewer: That is hard to find. Well, fun, okay, so you've got kind of a split role. Kind of moving on. One of the things we know ... Researchers have found that experience level of counselors, so being a newer, entry-level counselor, and the setting, particularly community mental health setting, can impact the experiences that counselors have related to their personal wellness and professional quality of life. I know on the survey portion you did the professional quality of life scale and I did review that a little bit so I know kind of where you are with it, but I wanted to ask you to describe a

little bit of your experience taking that survey, if any thoughts or feelings came up for you around the professional quality of life scale.

Participant: Yeah, so I worked for six months before coming here doing intensive in-home work and that just about killed me. My personal wellness and self-care has dramatically improved since leaving that job so it's nice for me to kind of reflect on how far I've come and just kind of knowing what it's like to feel burned out but now kind of feeling more balanced and having more flexibility in my schedule and my time.

Interviewer: Your scores were really good, and I saw a pretty high score on the compassion satisfaction scale which is a positive thing and really low on the secondary traumatic stress and burnout scale, so if ... and that was for taking it related to this current position. What kind of thoughts came up for you reflecting back on that other experience in intensive in-home?

Participant: Yeah, it was ... It would have been so much lower. That's ultimately why I left because it was just definitely seeping in to my personal life and creating a lot of unwanted stress.

Interviewer: Yeah, so you definitely feel more well now and more balanced. I think you used the word balanced.

Participant: Yeah.

Interviewer: If you were in intensive in-home and you took this scale, you feel like the scores would be very different for you?

Participant: Yeah.

Interviewer: Okay, so you kind of had some experience with burnout.

Participant: Yeah.

Interviewer: True that. Okay. How long were you in intensive in-home?

Participant: For six months.

Interviewer: Six months. All right. Yeah, that's a very tough role to play in the community.

Participant: I started out ... My internship was at a local inpatient setting and then going to intensive in-home so I kind of started with the more extreme cases and workload and then have worked my way down.

Interviewer: Have worked your way down. Okay. You feel good about where you are now.

Participant: Yeah. I love it here.

Interviewer: Good. Good. Well, let's kind of move into this. The next question is tell me about why you chose to work in a CMH agency. You started that discussion off by saying you started at the hospital so behavioral health and then you moved into intensive in-home and now you're here, and it's more of a balance. Tell me about why you chose this though.

Participant: Definitely the flexibility of schedule. Being able to set your own hours and take time off when you need it. Also being able to have more control over the referrals that you take. I don't have to take any referrals that I don't want to see so being able to kind of choose like, yeah, I think I can work well with them, or no, this is a little bit out of my comfort zone, or yeah,

I'm going to try this one but you know ... Really being able to set my own client base, not having too many with the traumatic stress. Being able to control, okay, I'm maybe going to have one sexual abuse case or something like that and not this feeling like you have to take tons of really stressful cases.

Interviewer: That's in this position that you're in now. Kind of thinking back about going into the field right out of graduate school, do you remember thinking about entering community mental health as opposed to school counseling or even private practice or some of the other options that might have been there?

Participant: My dad was a school counselor and so I was not inclined to do that because to me the school system is I don't know ... not that community mental health is maybe the most organized but to me the school system just has a lot of challenges and I also really wanted to focus on one-on-one relationships and not so much doing testing and some of the other responsibilities that school counselors have. I would love to do private practice one day, but I don't feel like I know how to start my own business or have the resources to feel comfortable doing that.

Interviewer: Okay, so that was your first job. Intensive in-home, and how do you remember that process going of looking for the job, finding that particular job?

Participant: I had actually when I was in my graduate program got offered a contract position with a psychiatrist in my hometown. Initially that was my plan, and I got scared off a little bit because it was contract work, and I really didn't have money saved up and so I was scared that I just wasn't going to be able to make it work. That was in my hometown which is close to the mountains, and my now fiancée is in school in another city and so being close to him definitely motivated me to look for other jobs, the intensive in-home being in the area is kind of what sold me on it, but I also was really drawn to that they seemed to have a lot of resources and they only used evidence-based practices. I felt like I was going to get a lot out of it, and it was salaried and had benefits and so that was very comforting to me just starting out and not having a lot to my name.

Interviewer: Salary and benefits was a big draw for you because you actually had something sort of lined up that might have been a good experience, but it didn't feel very secure financially.
It's tough to go out into the work world right out of graduate school. That's part of the process that I'm looking specifically at entry-level, that LPCA credential, because you tend to be limited in what you can bill and how you can just approach the field in general.

Participant: Yeah, and if I had worked for the psychiatrist, I would have had to pay for outside supervision so I kind of felt like I would have been more on my own. I think they had one other counselor that worked for them but even the psychiatrist only came once or twice a week because she had other

businesses. It would have really been a challenge for me to be just starting out and be that independent.

Interviewer: Right, sort of isolated almost, on your own. So kind of moving through and also you can pull on your current experiences and also maybe those intensive in-home experiences, I think they'll probably mesh well. We know that also in community mental health organizations, there are usually additional job responsibilities or duties that come along with direct client care. Things like paperwork, documentation, maybe use of specific technology, insurance, billing, sometimes Medicaid compliance, all of that tends to come along with community mental health that's not client care. What have your experiences been with those additional responsibilities?

Participant: I think during intensive in-home it was like having a second job because they required weekly treatment plans, monthly PCP updates. There was just a lot of paperwork that wasn't necessarily required by the state but that the agency required. That paperwork, I was always doing it at home at night and waking up early to do it so it really was like ...

Interviewer: Like a second job.

Participant: Yeah. It was draining. Here we use an electronic medical record system, and I think it's very user friendly. I haven't had to do reauthorizations yet because I'm not to that number of sessions with my clients right now, but I know that's coming...

Interviewer: But you will be responsible for reauthorizing?

Participant: Yes. I'm not responsible for billing. The system does that, and then we have a billing specialist who handles calling insurance companies and all that so that's really nice for me. I know it can be a challenge.

Interviewer: I think I noticed on your survey that you highlighted that you do take Medicaid funding, you take private pay, and then you also take various health insurance, things like that.

Participant: Yeah, I pretty much only see Medicaid, but I have a few Blue Cross/Blue Shield and we've gotten a couple self pay referrals, but I haven't taken any of those yet.

Interviewer: So with the Medicaid, I'm just sort of guessing that that's where the heavy paperwork and administrative pieces come in, more so than the others.

Participant: Yeah.

Interviewer: That's the authorizations that you're referring to.

Participant: Yeah. It's through ... We take MCO funding, and so I think they're called TARS, every so often, the paperwork

Interviewer: TARS. Yeah, which I've kind of heard are intense now almost like a repetitive process.

Participant: I think it's one of those things that once you have down it's easy, but it will probably take me a few tries to really figure out what they're looking for.

Interviewer: Then you're not guaranteed the authorization. You have to sort of convince them why they should give you the authorization.

Participant: That's where having detailed treatment plans comes in handy.

Interviewer: Yeah, definitely. This may apply more in the intensive in-home experiences, but how do you feel that administrative stuff that has to get done impacts your work with clients? Your ability to be a counselor with them.

Participant: I guess in intensive in-home we have pretty strict requirements that you were supposed to be using so many interventions per hour and a half session and you really had to document like I used this intervention for this amount of time, this intervention ...

Interviewer: Oh, wow.

Participant: So it really, I mean, you don't have that creativity or that flexibility to kind of bring in something that you just wanted to try and see how it goes.

Interviewer: Super specific intervention. Down to the minute.

Participant: Yeah, they have their own treatment manual and you have to choose interventions from that which to me coming right out of grad school is like, man, I want to try these theories that I've learned, but I was specifically told that talk therapy was not evidence-based and that it wasn't shown to work and that I just couldn't use it.

Interviewer: Couldn't use it. The client centered stuff.

Participant: That was saddening to me, but here I don't really think it impacts me too much. Maybe when I was first starting and I was more focused on a paycheck, it was harder when people no-showed or cancelled. Now it's just part of the work week. It's expected that some people aren't going to show up, but really doesn't take much time and it's kind of fulfilling because when you submit it, you're like, okay, I'm going to get paid for that now.

Interviewer: Are you contract here?

Participant: Mm-hmm.

Interviewer: You are contract, okay. So not a salary contract, so when you talk about billing, it's kind of like the no-show means no pay?

Participant: Yeah.

Interviewer: Okay.

Participant: So that's ... You know, when you're first starting out it's hard, but once you're established, it's not as big a deal.

Interviewer: Not as big a deal. Yeah, once you start to get a flow going. What about benefits? Do they offer any kind of benefit?

Participant: Mm-mm, no. Nope. That was definitely ... finding health insurance and all that was new to me.

Interviewer: Yeah, that's a struggle. You mentioned when you first started out in the field, that's what you were looking for. You were looking for that financial piece, so being able to sort of get comfortable with it and moving into this role. It sounds like it's been a positive thing for you though.

Participant: Luckily I'd saved up some money by the time I transitioned here and just kind of knowing how unhappy I was even having benefits and a salary, I just decided to kind of take the risk and ... I was really lucky that I got the

grant-funded position because it is salary, so no matter what I'm getting a stable paycheck every month so that takes some pressure off.

Interviewer: For that portion of your day, at least you know you're getting paid for it, and the rest of it is kind of based on clients' show.

Participant: That's what the owners really encourage people to do is to have some sort of stable morning work and then supplement in the afternoon.

Interviewer: I think we'll get to this in a minute, but I'm wondering if supervision is included in your benefits.

Participant: It is. Yeah, that is a benefit. Free supervision.

Interviewer: Free supervision. That is good. All right. Good. We'll come back to supervision in a minute. I kind of want to move on here for you. Can you describe the types of clients and client issues that you work with in community mental health? I know these may be different here versus intensive in-home as well, and I know here you're focused more on children, but can you just kind of give me an overview of the types of clients and client issues?

Participant: Yeah, so here it's all lower class children and families. The issues I'd say are more on the mild side. I see anxiety, anger issues. I think I have like one PTSD. ADHD a lot. Lots of kind of family problems with communication kind of. I'd say family stress comes up a lot with being lower income. You know, there are a lot of outside factors that impact these families.

Interviewer: Lower income issues, but generally speaking, it sounds like you are saying that the issues are fairly mild.

Participant: Yeah, I mean compared to maybe what I saw at the hospital or intensive in-home, I don't have any suicidal clients, knock on wood. Everyone has strengths ... I don't know. It's just not as ...

Interviewer: You don't get a lot of crisis.

Participant: Yeah.

Interviewer: Here, in this setting. Thinking back to intensive in-home, what do you remember about clients and client issues there?

Participant: I was working specifically with reunification and so people who had been at residential treatment facilities or foster care coming back into the home. I had one ... They were also children. I had one child client who had spent a year and a half in a residential treatment facility, came back to a family home, and within a day, spent all night with her in the hospital. Then she was at that hospital for like two weeks, then tried level two foster care, disrupted there after a week after getting physically aggressive with me.

Interviewer: Oh, wow.

Participant: Then her going back into the hospital. When I had left the job, she had been in the hospital for over a month. It was very intense, and there were lots of crises and ethically seeing someone when they're in the hospital, it was kind of tricky for me because it's just like how much can I really do when they're already being cared for by a whole treatment team.

Interviewer: More crisis, more serious, big issues that you noted, and then also kind of some ethical concerns. Then I heard you say physically aggressive with you.

Participant: Yeah. That was another reason why I left because I didn't really feel safe on the job, and I had expressed concerns about safety with working with this client because she had a long history of pulling knives on people and hitting and punching people. I didn't get a lot of support with that, and then ultimately was attacked.

Interviewer: That's one client in particular. If I remember correctly, intensive in-home involves you going into the client's home environment, and that can also mean that you're driving there. You're driving them in your vehicle, things like that. This particular client really made you feel unsafe. Would you say that was a general experience of not feeling safe?

Participant: Yeah, I think ... what was more common was not feeling safe in the neighborhood. We were kind of in a gang-prevalent area, but yeah. There were a couple clients within my team that had been known to be physically aggressive and the way this particular agency did it was that you can't go out in teams. You had a team, but you went out on your own. Everyone had their assigned cases so this finding scary going into someone's home all by yourself. We were working within five different counties.

Interviewer: You're spread out?

Participant: Yeah.

Interviewer: All over.

Participant: Very rural. Cell phone service isn't great. It was definitely scary. The driving, I guess that would go under one of the extra responsibilities took up at least two to three hours a day.

Interviewer: Wow. In your own vehicle.

Participant: Mm-hmm.

Interviewer: All right. Yeah, that's tough. Kind of thinking, and I know we're comparing both experiences here, but thinking a little bit about the clients and the issues that they face, how do you think ... How do you think that impacts you? Both professionally and on a personal level.

Participant: How their issues impact me?

Interviewer: Mm-hmm.

Participant: I definitely have a lot of empathy for my clients, and it makes me grateful for my family and my support system, and just kind of the privileges that I've grown up with. Yeah, it makes me think a lot about becoming a parent and what that's going to be like and kind of how I want to do things. I think that's probably what I think about the most is kind of my future and what that's going to be like. But I get a lot of joy from the kids here. I think working with children, at least for me, is just really encouraging and just fun. You get a lot of satisfaction out of it. Just seeing even small

changes and just knowing for some of these kids who don't get a lot of support at home, even just playing with them for an hour a day is so huge.

Interviewer: You do get a lot of satisfaction out of your job here. It sounds like it creates some reflection for you and kind of looking into the future and how you might do things in your own life. That's really good. Knowing that client issues do impact us as counselors, how ... What do you think prepared you to work with client issues and also to work in the setting of community mental health?

Participant: Definitely my graduate program. I felt very prepared and my internship too. Having seen those more extreme behavioral issues and really having kind of eye-opening experience of how bad things can get for families and the challenges that they face. I had a supportive environment where I had group supervision and individual supervision. I wasn't on my own. I think seeing that and then all the experiences in graduate school really prepared me.

Interviewer: Internship sounds like the biggest factor that prepared you for it. When you got into the field in that first intensive in-home job, what do you think prepared you for that? Because sometimes that can be a whole different experience for some people.

Participant: I don't ... I didn't always feel completely prepared because some of the issues we were getting specifically with kids that had mental retardation in addition to these behavioral health issues, that to me just was really challenging because that's not something that we focused on in graduate school, and it wasn't something that came up at internship. I didn't feel so prepared for that. They did have, I guess, maybe ten days of orientation which I think is unusual. They had a very, I guess, routine orientation process and training process for new hires. I did at least know their expectations, how they liked things to be documented, and all those types of things.

Interviewer: Would you say that orientation is kind of where you learned about those administrative pieces or any part of graduate school that would have prepared you for those things?

Participant: Yeah, all I really knew from graduate school was about writing progress notes. I did not know what a PCP was or much about ... We talked about treatment plans, but I think they look different from place to place, and so that was new to me. I had a general idea about the system of care, but I didn't really realize how messed up it is in North Carolina and kind of what we put these kids through with making them go through all the different steps even when you know they need a higher level of care, making them go through the lower levels first. I kind of learned that firsthand.

Interviewer: Learning the system of care in the details of the system of care. Okay. I'm going to guess and just say the Medicaid culture.

Participant: Yeah.

Interviewer: A progress note in graduate school looks very different than a Medicaid note.

Participant: Right.

Interviewer: Okay, and a treatment plan looks very different. A CCA looks different. You've got all those different pieces.

Participant: I don't know if in graduate school we really talked about CCAs. I think I was doing them at the hospital not knowing that that's what it was called. It was just our intake paperwork. When I started at the hospital everything was handwritten, and then they switched to an electronic system. I did have some experience doing digital medical records but I don't think they did that in school when I was there.

Interviewer: Probably not.

Participant: I guess we typed them, but it wasn't going into a system. It was just we were printing them out.

Interviewer: In the file.

Participant: Yeah.

Interviewer: Lots of things. How do you deal with stress or self-care?

Participant: Definitely spending time with my dog and my fiancée. I'm lucky here. They usually have a break at midday so sometimes I'll go home and take my dog on a walk or do mindless things on my computer like Pinterest, stuff like that. But yeah, just taking time to myself when I get home. I don't have to do notes right away. I mean, they should be turned in within a week, but it's nice when I go home to make dinner, watch TV or take a shower or whatever, and really leave work here.

Interviewer: So you don't feel as pressured to take that with you so it sounds like disconnecting from the work a bit is helpful, and that comes in the form of your dog, family, kind of finding support.

Participant: Yeah.

Interviewer: Okay, good. Kind of moving into another area here. We do think that counselor development is facilitated a lot by supervision experiences. We also know that's a requirement for entry-level professional counselors. Can you describe for me a little bit about your experiences with supervision? Maybe even pulling on what it was like then and what it's like now?

Participant: Yeah, so in intensive in-home, my direct team supervisor, she had her master's degree in social work, but she hadn't done a lot of direct practice, and was not from North Carolina, had just moved. There were a lot of challenges. There was a lot of hostility on my team I'll just say. Things were not ... We weren't meshing well. Things just were really tense. My licensure supervisor through was via Skype, and he was a psychologist. That experience was different.

Interviewer: These were two people that sort of provided some level of guidance to you that were not part of the actual counseling field. You have a social worker and a psychologist.

Participant: I don't think either one of them understood the counselor identity. I didn't get a whole lot out of supervision, and it tended to be a lot about how we're going to handle this crisis this week. I never felt like my long-term development was really being worked on, like I wasn't focusing on a particular skill or even a particular area. It was just like this crisis, this crisis, this crisis. But here one of the owners, who has an office across the hall is my supervisor. It was initially her husband, who's a clinical social worker, but then when she got her LCPS maybe like a month ago, she became a supervisor. He has a group that I was attending, but now that my schedule has gotten busier ... They meet in the other location office so I stopped doing that for now just because it's an hour drive.

Interviewer: I was going to say, that's far.

Participant: It's really nice because she is right here and so ... I mean, we check in pretty much every day and then we have an hour a week to sit down and go over things. She's awesome about sharing resources with me and so ... I get books and just creative ideas.

Interviewer: Lots of support. She's on site. You connect with her on a regular basis. You have a formal supervision hour, get good resources from her. It sounds like that counselor identity piece is back for you.

Participant: Yeah. She went to the same graduate school as I did and so we have a lot in common there with her knowing exactly the classes I took.

Interviewer: She definitely has counselor identity.

Participant: I think it's helped a lot.

Interviewer: Good. Good. You said that it is paid for so it's included here. You do not have to go outside this organization to get your supervision.

Participant: Right.

Interviewer: Okay. That's a great benefit. That's a great benefit.

Participant: It is.

Interviewer: So just thinking in general, can you discuss any positive or negative components of supervision for you that you've experienced within the setting of community mental health?

Participant: I think it's really all been positive for me. Like I said, really getting connected to resources and yeah. She also will help with the administrative aspect of things like learning how to do the authorizations and all that stuff.

Interviewer: She's in it as well so she is able to help you with those details.

Participant: Mm-hmm. She actually does the community mental health consultation stuff too so we were together on a lot of different things. We work well together.

Interviewer: Okay.

Participant: So we work together a lot.

Interviewer: That's great. Kind of thinking back to your other experience in intensive in-home, that wasn't such a positive experience for you.

Participant: Yeah, I think having it over Skype first of all and he must have been supervising a lot of people because he would kind of get details confused. I never felt like he really knew me. My program that I was doing was a pilot program so they did some things a little bit differently than the other programs that he was familiar with, but he never kind of learned the difference and was always kind of messing up the name of what program I was in and like what my responsibilities were so ...

Interviewer: You really didn't feel like he connected much with what you were doing.

Participant: He was helpful. I called him in crisis one time because I felt like we needed to hospitalize someone and my direct supervisor did not. That was the goal of our program, to keep kids in their homes, so any time they disrupted it looked poorly on our program, but that again was kind of an ethical thing.

Interviewer: Sometimes they need to go to the hospital.

Participant: Yeah. They're unsafe. I want them to be in a safe environment and so I did call him during that crisis and he was supportive.

Interviewer: Good. I know one of the issue that sometimes comes up with supervision is when you've got a supervisor who's also part of the organization, some research has shown that that can be a negative as well because that person may be doing hiring and firing and that kind of evaluation. What are your experiences with that sort of thing?

Participant: Yeah, I haven't had that concern yet. I can see if you were maybe unhappy with something on an agency level or even just really unhappy in the position, how it might be uncomfortable to talk to your boss about that because you wouldn't want them to think that they should get rid of you. Luckily I trust my supervisor and I think she's empathic enough that if I were having a problem we could talk about it without it being about the hiring and firing process.

Interviewer: Okay, so trusting your supervisor is important in this type of setting

Participant: I think that having that personal connection and feeling like they really know you and understand where you're coming from.

Interviewer: Okay, good. Good. It sounds like you've had some really good experiences. They started off ... a little struggle, and then you really found a place where it fits for you.

Participant: Definitely.

Interviewer: Okay. Anything else that you would want to talk about or want to add to this interview about community mental health experiences?

Participant: I'm trying to think. I don't think so. I guess one thought that comes to mind is when we're talking about being prepared, I think it's hard to find internships now from what I've heard and I don't know. It'd be great if programs could figure out a way to get more of that hands-on experience before you're out in the world.

Interviewer: Yeah, so focusing on the internship experience would be important to you. You mentioned it was a good experience for you. It's where you got a lot

of that hands-on learning, but was it hard for you to find an internship placement?

Participant: No, I was lucky. I know a lot of people in my program did struggle. This used to be an internship site. I know they're not taking interns anymore. I've just heard that it's kind of been a difficult process for people ...

Interviewer: I've heard that too.

Participant: Yeah. I think that's unfortunate because, like you said, that's where I got a lot of my learning.

Interviewer: Yeah, okay, so that would sort of be your statement of ...

Participant: Yeah.

Interviewer: In the graduate program, helping counselors get ready for this experience. Okay.

Participant: Yeah, it's different to talk about it versus see it firsthand.

Interviewer: Very. Very different. Well, those are my questions. Do you have any questions or any final comments?

Participant: I don't think so.

Interviewer: No? Okay. Well, thank you so much for doing this. I really appreciate it. You gave me some really great information. Let me go ahead and turn this off.

PARTICIPANT 7

INTRO DATA MISSING FROM TRANSCRIPT/ RECORDING

Participant: Yeah, to where I kind of fit the role really well. Yeah, ended up here and luckily there was a job open, so I took it.

Interviewer: OK, so really your program prepared you for this type of work, but I heard you say that you don't know if you really chose to be a vocational specialist.

Participant: I wanted to be a counselor for a very long time, since I was 12, 11 years old. I knew there really was no other work I wanted to do. I love talking to people, I love hearing people's stories and I love just deciphering problems for people and understanding them at a deeper level. Especially with how it relates to their beliefs and their world views.

Yeah, so when I was looking for a grad program, this program just kind of fit that idea for me very well. So when I was accepted and I didn't know it would open up this whole other passion of mine for employment and for helping people find their own passion their lives.

Interviewer: OK. Good. Part of it was that it fit for you and the other part was there was a job there for you. Yeah.

Participant: The job was nice.

Interviewer: Good, good. That's a challenge sometimes. You know what you want to do or you know the area and then when you graduate sometimes you have to take what's there to get your feet wet.

Participant: Yeah, and I've definitely seen a lot of, yeah, my friends who have graduated from the program as well struggle with finding a job. I was definitely lucky in this that I could do what I really like to do.

Interviewer: Good, very good. OK, well I'll keep moving here. I know that in community organizations a lot of times you get put into a position, so for you, vocational specialist, but I also know that in community mental health that job sometimes gets pushed to the limits, other responsibilities or duties along with client care.
So things like paperwork, documentation, using different types of technology, dealing with insurance. I noticed you put pretty much 100% Medicaid billing source.
What is your experience of those types of things been since you started in community mental health?

Participant: Yeah, so case management actually I enjoy because it gives me kind of a time to debrief for myself. It gives me a time to think about the techniques that I've used with my clients, to really put a name to it.
 It's really kind of that time for me to kind of sit back and really think about what I'm doing with a client.
 I really enjoy it, not really enjoy it, but I do find benefit in writing my notes and other line, writing person-centered plans.
 Other than that we actually have a program assistant that helps with all of our authorizations ...

Interviewer: Oh good.

Participant: ... to Medicaid, so I'm really not doing much of that. I help in any way that I can especially if the person's Medicaid gets cut off and then going back and helping them fill out forms and stuff, but that really counts as a time to sit and talk about different things that come up with my clients as well.

Interviewer: OK.

Participant: Yeah, so case management I do some of, but yeah, I don't feel like that's my whole job.

Interviewer: OK.

Participant: If I am feeling that way then there's definitely opportunity to have support and have people step in and maybe take some of that load off of me if I'm feeling burnt out by so many notes or so many things like that.

Interviewer: OK. Good. You do have support there that helps you with the authorization pieces, so you have limited responsibility when it comes to billing.

Participant: Yes.

Interviewer: OK, OK. Your main paperwork, case management components are going to be case notes, so documenting your time, what you did, how you did it. That sort of thing?

Participant: Yes.

Interviewer: OK. OK, good. Thank you. I know that you started to describe this a little bit, but can you give me a little more detail about the type of client that you see and client issues that you work with in this setting?

Participant: Mm-hmm. (Affirmative). Yeah, we work with severe, persistent mental illness, so all of our clients typically have a psychotic disorder that can be either schizophrenia, psychosis, schizoaffective. Those are our main types, but we also can serve people with major depression, with psychotic features, bi-polar with psychotic features.

I guess it really comes down to our team lead, that's really who does the intakes for our team, so she with a psychiatrist will really say if someone's appropriate for our services or not, since we are kind of the most enhanced service, outpatient service that there is.

It's sort of up to me, but not so much up to me about who I serve. It's really up to my team lead and the psychiatrist who they bring on and who they feel is appropriate for the team.

Then yeah, we do smaller teams. We're a small team so we have about 50 clients. On our team there's about 7, 8 I think staff members. Then between all of us we see about 25 people a week.

Interviewer: OK.

Participant: That's the maximum people I can see is 25. I don't see everyone on the team, but I try to get around, especially if they have employment issues. I try to get around and see who I can. Yeah, I think that pretty much sums it up.

Interviewer: Yeah.

Participant: I really work on my specialty employment. I really try to keep that a focus, but I've actually done phase one of the ET with one of my clients and starting into phase two for more cognitive processing therapy and then I picked up some of the DBT kind of skills with some of the other clients who my team lead is doing, the main DBT therapist with ...

Interviewer: OK.

Participant: Yeah, so that's really, I mean the clientele that I work with and ...

Interviewer: OK. A pretty heavy load of psychosis - based disorders. OK. Yeah, that's heavy stuff that you're doing.

Participant: No, it is. I never really saw myself working with this type of population. I guess it's just really scary coming from, when you read about it in the DSM or whatever, it sounds a lot scarier than it is.

Interviewer: Yeah.

Participant: Yeah, I absolutely really love the people that I work with. They're just fascinating.

Interviewer: OK. Yeah, it is a very interesting population group for sure. Good. OK. Keeping it going here, how do you think that the issues your clients face regularly, so your clients' issues, how do you think that impacts you personally and professionally?

Participant: It's really hard sometimes especially with a lot of my homeless clients. It's so hard to just drop them off at the end of the hour session. It's like well, you've talked about all your problems. Well, now you're back into it. You know?

Interviewer: Right.

Participant: It sometimes feels like we didn't solve anything. That can be really, really hard to see. Yeah, just to see them so depressed and there's nothing really that you can do in that moment. You have to go back to the shelter. It's not maybe a place you want to be, but that's your only option right now, so definitely it's a struggle to see and especially just to see the hypocrisy in the mental health system. Especially a lot of it because our clients are so marginalized, because people even in the mental health system don't understand psychosis, don't understand schizophrenia. So when they see that they don't want anything to do with the person and it's so sad because you get to know the person on such a deeper level that you don't ... You take in a lot of their problems and issues because yeah, I've been working with some of my clients for a year now. Since I've been a new therapist, so you get to know them on such a different level than most people. Just know all about them; their wants, their desires, their everyday emotions, their everyday struggles and the greater struggles that they've faced too. It's definitely hard. You just have to keep it balanced for yourself and get the support and get healthy when you need to so that you can go back in there and do it week after week to help them.

Interviewer: Yeah. Things like homelessness, that's a big one. Would you identify any other sort of patterns of issues that your clients face that would impact you like that?

Participant: Yeah, homelessness, substance abuse, unemployment.

Interviewer: Right.

Participant: Yeah, that's a big one too. Disability services, just trying to get them if they need disability, if their Social Security. Trying to set them up with that.

Interviewer: OK. Good. For you, you know it impacts you, but you try to look for that support and balance.

Participant: Mm-hmm. (Affirmative).

Interviewer: OK. Good. What do you think prepared you to deal with this type of work as a counselor?

Participant: I don't know if anything really could prepare me. Just the knowledge that I have from my graduate program. I did read a lot of studies on schizophrenia and schizo-affective, different psychotic disorders and so I think it was just a combination of my sympathy for people with mental health, mental illness and then just knowing a lot of the research that I did know.

Especially with knowing a lot about employment and the different techniques that work and the history of job placement, patient rehabilitation. I did a stint of intern for that and seeing that process versus the process that I use.

I think that just really prepared me to kind of know that it's going to be a long term process and not something that's just short term or short fix, that it is a long term fix hopefully that we're working towards.

Interviewer: Right.

Participant: Yeah.

Interviewer: OK. Some of your graduate experience and then mostly the hands-on stuff is what you identified as helping you to prepare for this type of work.

Participant: Oh yeah, definitely. The research is great, but definitely putting it into practice and then again, just having the support that I have on my team and with my supervisor being sympathetic to what I'm dealing with and how difficult it is.

Interviewer: OK. Great. All right. I think you started to talk a little bit about this, but tell me a little more, how do you deal with stress or self-care issues when that comes up for you?

Participant: Yeah, I work out a lot.

Interviewer: OK.

Participant: I go running and that really helps with the endorphins, getting those back up if I had a really, really tough time. Just finding joy in my own personal life.

Interviewer: OK. Finding joy in your own personal life, working out a lot. OK. You use the word support throughout this interview, so that's been professional support, but now you're saying your own personal life, so I'm imagining personal supports.

Participant: Yes.

Interviewer: As well.

Participant: Yeah, people who can listen to me vent if I've had a difficult time.

Interviewer: OK.

Participant: Parents, family, friends. Just having another level of people who can commiserate with me too.

Interviewer: Right. Yeah, that's very important. OK, just a couple more questions here. It's been considered that counselor development is facilitated by supervision. That's the theory, that's what we would like to believe. Counselor development is facilitated by supervision. We also know it's a requirement for entry level counselors. Can you tell me just a little bit about your supervision? How that happens/ Where that happens and some of your experiences with supervision so far?

Participant: Yeah, so supervision happens in this small little room right here that I'm in.

Interviewer: OK.

Participant: I meet once a week with my I guess, main supervisor I have through the LPC board where I signed up. My main supervisor, but supervision happens everyday. We have a team meeting actually for an hour every morning and that's really I think, between that, I don't know, I get supervised I think every time I have a problem.

Interviewer: OK.

Participant: It really is so ongoing. We have formal supervision with my main supervisor weekly. Once a week, but honestly I get supervised all the time. It's never a moment where I don't, I'm not working with someone else on the team because like I said, there is about two or three people on kind of a smaller team working with a client so if there's ever a problem I would just go to that other person.

Have you seen this from this person? Is this weird, this baseline? How should I be responding to this? How have you responded to that? Really just getting those tips and hints for what's worked with a client and what hasn't worked from someone else, it's just life changing for me.

I don't know if I would have ever been at the level that I feel like I am at now, looking back, if I didn't have the rest of the people on my team. If I didn't have my supervisor to call and to talk with and just having such amazing again, support.

Interviewer: Yeah, support.

Participant: Yeah, so the people that are on my team.

Interviewer: OK. Supervision is constant for you. You've not only had the formal requirement, but you just have access to supervision and support all the time.

Participant: Pretty much, yes.

Interviewer: I love it. I think that's really important, so that's very good. That's very good. OK, kind of wrapping up.

Whether it is related to supervision or your experience with clients.

Whatever you can think of, can you talk a little bit about positive and negative that you've experienced just different components of supervision in the setting of community mental health?

Participant: Yeah, the positives are all great. The agency that I work with, that they've come from a very person-focused perspective which is very much in line with my own views of how to counsel and how to help people.

Being person-centered to the point of people on my team have helped the clients fire us before.

Interviewer: OK.

Participant: They're helping them. We had one guy actually come in and want to use the phone, so our program assistant helped the person use our phone in the back of the office to call another staff member and actually fire that staff member.

Interviewer: OK.

Participant: Actually fire us as a whole team.

Interviewer: Oh wow.

Participant: I think that really sums up the positives, that our whole team is so person-centered and person-focused that we will really help that person do what they need to do.

At the same time it was very sad to be fired by that person. I hope they will come back to us and I hope there'll be some engagement that we can work on with them. I think that really sums up that we're not only person-centered, but focused on helping the person with what their goals are every time we meet with them, but that it can be an up and down with people sometimes, that they hate us one week, they love us the next week. That's really hard sometimes to keep on track. Oh, do you like me this week? Do you not like me this week? Kind of you have to walk on eggshells sometimes around people, but once you get into a flow, I would say the majority of our clients enjoy our services once they realize what those services are. Once they realize what other services are out there that we are, we're a pretty intense service.

We see people twice, maybe three times a week or more if they need, but I think a lot of the times people get to a point where they actually enjoy that. We kind of wear them down to where they like us, which I think is an interesting tact.

A lot of the people we work with don't have those natural supports. Don't have support really from anywhere else. They've really burnt a lot of their bridges from going into psychotic symptoms, having delusions, having auditory and visual hallucinations where they will lash out at people.

A lot of our clients have been in jail and have been put in jail by family members. Which is really tough to see. I think we're just a unique aspect of that. I can build a really long term relationship with someone and there's no time limit to our service. It's not like oh, I'll see you for six months and then that's it.

No, we can see each other for as long as you need to see me or until we feel you're better or until you feel really just want nothing more to do with us.

I think that it can be really freeing in that, that we have so much time to work on things together, but it is also really overwhelming in that that there is so much that someone needs help on and it almost feels like it's never going to get better.

Interviewer: Yeah, yeah. It's a little sense of hopelessness. This may never get better. It's really big.

Participant: Yeah, yeah. As long as you can kind of keep that away, keep that down and really just keep looking for the positives of it and seeing those small successes, that has really I think been a huge help in kind of scaling things down for me.

Yeah, I want to see, I'm a big picture person. I love seeing the big picture. I love seeing where people are going to go with their lives and what they're going to do.

I just have to keep scaling it down to remind myself that this is their life and we're just a snippet of a part of it. There's so much more that there is going on. That the part I see is just so much smaller than what I may think it is.

Interviewer: Yeah. What a great outlook. Yeah, you have a really good outlook for this type of work.

Participant: Thanks.

Interviewer: Yeah, you really do.

Participant: Yeah, and I give that back to my supervisors and the people that I've known through doing this work and doing this job and just being in this agency. I think that's kind of the outlook that they instilled.

Interviewer: Good. A lot of support from the agency, from supervision. Again, this is all confidential here, so feel free to say also some maybe negative things. I'm wondering if there are any, from your perspective, any disadvantages or any issues that you feel come up with having supervision in this environment. Because it sounds like you're supervisor is part of the agency.

Participant: Mm-hmm. (Affirmative). Yeah, he is. He's I guess, part of upper management. He loves our services. He has formed a lot of the assertive community treatment team throughout North Carolina but also throughout the country.

He not only I think does a lot of advocacy for mental illness and for psychosis, but he does a lot of advocacy for ACT teams, not only in North Carolina, but throughout the states.

That's been really helpful to have such a person who believes in what I do and believes that this is the only way to help people with psychosis, who have really multiple hospitalizations and wants to give people more freedom and doesn't want to take it away.

That's really refreshing to have every week, to really have someone challenge that status quo, that we get so used to.

This person lives in a group home. This person's on their fifth hospitalization. We don't know what to do with them. It's like, well, what do they want to do? He really comes at it from a person-centered focus which is just, yeah, again, I know I wish I had more negatives, but ...

Interviewer: No.

Participant: ... it's just been such a positive experience all around.

Interviewer: Good.

Participant: For being out of grad school and just having the type of agency that I work with and the type of supervisor I have, I really think I just lucked out.

Interviewer: I'm so glad to hear that. Yeah, I can imagine that helps when you have someone who really believes in what you're doing and can maintain that positive focus.

Participant: Yeah. He definitely does, so it's been such a strength.

Interviewer: Good. Good. Those are all the formal questions that I have for you. Anything that either came up for you during this interview or any feedback or anything you just feel like you need to process or wanted to add to this discussion?

Participant: No, I think yeah, I definitely hope I gave you a look at what you wanted to look at it from me and yeah. I love this. This is really what I've always wanted to do and I just have to pinch myself sometimes to make myself believe that this is where I am in my life and I just really enjoy it.

Interviewer: Good. I am so glad to hear that. It's nice to hear, I know I'm going to get a good mix of really positive and really negative and somewhere in between, so it's good to hear the positives.

Participant: Yeah, yeah. Again, I just lucked out with the program I went to and the people I've met. Actually was living in Ohio, so now moving down to North Carolina has been a different kind of experience for me.

Interviewer: Sure.

Participant: Yeah, I don't know, just being in a place where I feel like I can flourish and grow as a professional has just really given me a lot of hope for the future. Really excited.

Interviewer: Good. Well good. Well, welcome to North Carolina.

Participant: Thank you.

Interviewer: Yes. Participant, I think that's it for me. I really appreciate your time. You do get a \$15 gift card for Amazon.com which I know is always fun.

Participant: I'm excited.

Interviewer: You will get that via email here sometime today, it will come to you through email. OK?

Participant: No problem. All right. Well thank you so much, Interviewer.

Interviewer: Thanks. You too. Bye bye.

Participant: All right. Bye.

PARTICIPANT 8

Interviewer: My recording going here.

Participant: Okay.

Interviewer: Just a reminder, I am not recording the Skype part of this. I am just recording audio.

Participant: Okay.

Interviewer: All right. Well, I gave you the questions in advance, so hopefully you had a quick chance to just look at those.

Participant: I did.

Interviewer: Okay, good. Well, thank you so much again for doing all of this and I appreciate you taking the time to do this survey portion. Did you have any questions about anything before we just get into this?

Participant: I don't think so.

Interviewer: Well, great! Just to get started, I wanted to learn a little bit about your experiences of being an entry level counselor in community mental health agency settings. Could you tell me a little bit about your job and what that's like for you? Just kind of your role?

Participant: Yeah. Right now I am a clinical assessor and outpatient therapist working for a nonprofit and we have a contract with the local juvenile justice treatment continuum. I travel to six counties and do assessments for youth who are in the court system.

Interviewer: Wow. Six counties.

Participant: Yeah.

Interviewer: Okay. Wow. Your title is assessment therapist?

Participant: Assessment counselor. I carry a small outpatient caseload.

Interviewer: Okay, and it's primarily within the juvenile justice system?

Participant: I would say that's where about 80% of our referrals come in, but we do get referrals from local DSS agencies and other providers.

Interviewer: Okay. Wow. All right. It's for a nonprofit, you said?

Participant: Right.

Interviewer: Okay. All right. I know you filled out the survey and part of the survey was completing the professional quality of life scale. One of the things that we have found through research is that the experience level of counselors, as well as the setting of counselors, can impact how we see our professional quality of life. You took this scale and I hope it was a good experience for you, but can you tell me a little bit about what that experience was like for you? Completing the professional quality of life scale? Maybe thoughts or feelings that came up when you were reviewing some of those questions?

Participant: Yeah. I thought it ... I hadn't done the exact same scale, but I'm doing the trauma focused learning collaborative with the North Carolina child treatment program and we did a similar scale, that in terms of like secondary trauma, since that's what we're working on. It wasn't the exact same questions. I really enjoyed getting that feedback and kind of seeing where I was maybe a month or two months ago and then seeing where I'm at now. That was nice to see.

Interviewer: Okay. That was good. So you had seen questions similar to that, but not this particular scale and you liked getting the feedback?

Participant: Yeah.

Interviewer: Okay. Did it bring up any kind of thoughts or feelings for you about your experiences as a counselor, the setting of community health, or just in general?

Participant: I think it definitely brought up what I need to work on for myself and prioritizing my own development so that I know where my need areas are. I think I was pretty happy with where I scored on everything but just being aware of where those areas might go up and down depending on the clients that I'm serving or how busy my schedule is or different things that I can't control; commute, those kinds of things.

Interviewer: I looked at your scores just briefly and your scores were good, very good. Not traumatized, not burnt out, and your compassion satisfaction was actually pretty high as well. That's positive; hopefully that was some good feedback for you.

Participant: Yeah, it was good. It was good to see.

Interviewer: Good, and it just gave you an opportunity to sort of think about managing that as you move forward. Okay. Well, good. Good. All right, well kind of moving on here, can you tell me a little bit about why you chose work in community mental health? As counselors we have lots of options; why did you choose community mental health?

Participant: I choose community mental health ... My degree is actually in school counseling, but I choose to do the LPC track as well to give myself some options. I initially chose it because I couldn't find a job in the schools, but then once I started working with the agency that I'm with now I really found out that my values are aligned with this agency and working to keep children in their homes and with their families is a big value of my personal life, and so that keeps me working for the agency in the community that I work for.

Interviewer: Okay, so when you first started out in the field you were looking for school counseling, couldn't find a job, and so you found a job in community mental health and once you got there it seemed to fit for you?

Participant: Mm-hmm.

Interviewer: Okay, good. That's good information. Okay, well, one of the things we also know is that in community mental health there usually are some additional job responsibilities and duties that come up besides client care. Some of those things might be paperwork or documentation, dealing with compliance issues, all kinds of stuff. Can you tell me a little bit about your experiences with those extra responsibilities in community mental health?

Participant: Yeah. Paperwork's always, I think, a struggle for counselors who work in the community especially. My current role has a lot of documentation. I do clinical assessments so it's a lengthy document. I feel like I spend as much time working on the document after I do the assessment as I do when I'm with the family doing the assessment. I feel like, and that's probably just me wanting to make sure it's good, and then, having to turn it in within 24 hours is not always possible because I have 2 assessments this day and 2 assessments the next day and so because it's going to take me 2 hours to write up an assessment that write up time doesn't always come within 24 hours of when my due date is.

Interviewer: Wow. You do a lot of assessments and that means double time because you have the assessment with the client, but then you have to write up the assessment, and it sounds like you have a 24 hour requirement of turn around.

Participant: Yeah. The deadline within my company is 24 hours. My supervisor is very generous and says what's your personal deadline for yourself, and it's 48 hours, and then from there if it's going to be late beyond that we just talk about it. It does feel like that communication with my direct supervisor is really helpful in making myself feel like if I get 2 assessments behind, as long as they know my plan to get caught up, then we're good.

Interviewer: That's good. They give you some flexibility with it, but there's still some pressure to get it done?

Participant: Yeah, definitely.

Interviewer: Okay. Any other kinds of either paperwork or other additional responsibilities that come to mind when you think about community mental health?

Participant: I just think about having to make sure that we're following our state standards and what is in a pre-service packet. Before I do an assessment there is paperwork that has to be completed, before I admit a family into outpatient there is paperwork that has to be completed, and before the counselors who are referred to admit them to their services, there's more paperwork to be completed. It would be really nice if all of that paperwork could be a one time shot because it just feels like that takes up a lot of time for a lot of different counselors on a lot of different levels.

Interviewer: Okay, so you've definitely heard this is a theme for other counselors too, that it's a lot of paperwork that takes up time away from actual client care.

Participant: Yeah.

Interviewer: Okay, okay. If I remember correctly I think you listed that you work with a lot of Medicaid funding, grant funding, state funding ...

Participant: Right.

Interviewer: It's all state based somehow or another.

Participant: Right. Yeah. I'm really blessed that the agency that I work for there is a whole department that does UR and authorizations and I get my paperwork ready and they make sure it's good to go. I feel really lucky that I'm not submitting for my own authorization.

Interviewer: Good. So you don't have to worry about the authorization piece of it. That's good.

Participant: No, I just have to make sure that it's good enough to go. If they say it's not good enough, that "We won't get authorization," or "This isn't right," they send it back and I redo it, but I don't have to send it off myself and I like that.

Interviewer: You like that, that seems like a big burden taken off of you.

Participant: Yeah.

Interviewer: Yeah. Have you ever been a position where you have to do those kinds of things yourself?

Participant: Before I was a counselor, when I worked in therapeutic foster care, I used to have to submit for authorizations and that kind of stuff.

Interviewer: Okay. So you know. You know it takes a lot of the burden away from you because you do things before, okay.

Participant: Yeah, definitely.

Interviewer: Good. Well, I'm glad to hear that. That seems to be a theme that I am picking up on that a lot of organizations have realized that that piece of it is too much to put on the individual counselor, so I'm really happy that I'm starting to hear this often.

Participant: Yeah, definitely.

Interviewer: Okay. Well good, good. Can you tell me a little bit about the types of clients that you work with? I know you mentioned juvenile justice kinds of things, but tell me a little bit more in detail about the types of clients and the client issues that tend to come up for these folks?

Participant: Usually when I see a family or a youth, they have come into the legal system for some reason. Either they have been aggressive or non-compliant at home or they have had school issues that have led to legal issues. A lot of the kids once we get into the assessment I find out that have habitual trauma history and so helping to navigate and connect them to the trauma informed services and make sure they're getting what they need. After they see me initially then I do TF-CBT as well so working my outpatient caseload is probably like, 80% trauma right now with the goal of it being probably 100% of youth who have experienced trauma.

Interviewer: Wow. That's a heavy trauma caseload.

Participant: It's okay. It's only 4 or 5 kids, but I don't have any normal, "I'm having trouble at school," kind of things.

Interviewer: You get the heavy stuff. You get the severe issues to the point that this family has found themselves in a legal situation.

Participant: Yeah.

Interviewer: Okay. Well, how do you think that those severe types of issues impact you as a counselor, both professionally and personally?

Participant: I think professionally it is hard to hear some of those things, especially if I'm just doing an assessment and I may not ever have contact with this family beyond the assessment. I don't get to see them through treatment, I don't get to see them through the healing, or I don't get to see them through things looking better, so I feel like I get to hear the heavy stuff and then maybe I can, you know, through collaboration with other clinicians or other agencies get to hear the success stories on the back end, but just doing assessments is sometimes really hard because of where they're at right now. Where a family is at right now, knowing that I'm going to make a referral and I hope that they're going to get what they need but...

Interviewer: But you don't know.

Participant: Yeah, that not knowing is probably the hardest thing.

Interviewer: Okay, so not knowing is the hardest thing. You hear their story and then you don't get to follow it through to the good stuff, to the positive things, the healing.

Participant: Yeah.

Interviewer: Okay.

Participant: Then I think just personally, just being really tired. Hearing the heavy stuff is really exhausting and I can definitely tell the difference if I had a more challenging CCA or assessment. I feel much more tired after those. Helping myself identify, "Hey, this one looks like it's going to be a tough one so let's schedule some time right afterwards to go take a walk," or do something else so that before you have to walk into the next assessment you've gotten past that first assessment.

Interviewer: Okay. So you know it can be exhausting, it can really impact you and you sometimes try to schedule it out so that you can be ready for the next thing that's coming your way.

Participant: Yeah. It's real hard to do 2 back to back and then not have any time to process what you just ...

Interviewer: Yeah, yeah. Okay. So it does impact you professionally, and do you ever notice it kind of moving into your personal life?

Participant: I feel like that's probably where I was a couple months ago. I had a lot of really heavy things right after one another and then on top of that some just the additional stresses, the busy weeks and I was out for training, playing catch up, that kind of stuff and my husband actually mentioned, "You seem like you're really burnt out." I said, "I could really do this job for several more years and not feel burnt out," and he goes, "I really think you're already burnt out," and I was like, "Aw man."

Interviewer: Okay, so you thought you had it together.

Participant: Yeah, I thought I was doing a pretty good job and then he's like, "No, I think you're kind of burnt out."

Interviewer: Okay. So it can move into your personal life to the point that your husband is even seeing the symptoms of burnout and gets concerned?

Participant: Yeah.

Interviewer: Okay.

Participant: Then that impacts the way maybe how patient I am with the kids or with him, or maybe he was noticing things I hadn't noticed.

Interviewer: Yeah, okay. Wow. Well, kind of changing directions a little bit, so we've talked about the work, we've talked about how it impacts you, can you talk a little bit about what, what do you think prepared you to deal with this type of work as a counselor?

Participant: I feel like my counselor education program did a lot of focus on self care and taking care of yourself. I did take several classes in the expressive arts

certificate program. I didn't finish the certificate program, but I took all but one that I needed for that.

Interviewer: Okay.

Participant: There was a lot of focus while I was in graduate school about self care and then how bringing that in to ... I use it much more for my own self care than I do in therapy with my families, so using that knowledge for me has been really helpful.

Interviewer: You got to take some classes on expressive arts, and that has helped prepare you to at least focus on self care?

Participant: Mm-hmm.

Interviewer: Okay.

Participant: Yeah.

Interviewer: Anything else come to mind when you think about what prepared you to be a counselor to do this type of community work?

Participant: I think of previous jobs that I had before I decided I wanted to go back and become a counselor. I worked in mental health after I finished my undergraduate degree and worked in a field ... I was on call, I was crisis support, and knowing that that was going to be what I was going into again after graduate school, so I knew what to expect. I knew that work was not always over at 5 o'clock, and sometimes you're not over at 5 o'clock on Friday, even, so knowing that sometimes that work's going to spill over into what other people might call their personal time I think has helped prepare me. I wasn't going in expecting this to be a cakewalk.

Interviewer: So you knew what it was going to be like? You watched it happen firsthand, the crisis environment and that kind of thing?

Participant: Yeah.

Interviewer: Thinking a little bit back to that question about those administrative duties, whether it's paperwork or billing or authorizations, those kinds of things, would you say that other than the prior experience before graduate school, would you say that you felt prepared for those pieces?

Participant: Outside of my previous experience I would say no, that I would not have been prepared for that if I hadn't had that experience prior to grad school and that I didn't get that piece of how do you write a note? Or how do you write a good assessment? That piece was definitely not focused on in grad school so you got how to do the therapy but not how to get paid for it.

Interviewer: Which is very important.

Participant: Definitely, yeah.

Interviewer: Okay, so really don't feel like you got much preparation for some of the pieces of community work.

Participant: Right. Yeah, no. I think in my education, no, definitely not.

Interviewer: Okay, okay. Well, kind of moving back to the idea of self care, so you mentioned that you use a lot of the things that you learned in the expressive arts classes for self care, but can you maybe expand a little bit

on that and talk about how you do take care of yourself and manage stress?

Participant: Well, I try and stay physically active. I teach some dance classes which sometimes help with the stress and sometimes compound the stress. I teach for another nonprofit in town and I teach free dance classes for pretty much the same population that I counsel during the day.

Interviewer: Wow.

Participant: What used to be my self care prior to me being in my current position because I used to do it when I was in grad school, that was great self care then, but now I maybe need to rethink that. Teaching dance is usually helpful. It kind of gives me a creative outlet, definitely staying physically active, and then I use scrap-booking or journaling as a way to process my feelings. Sometimes I will make a scrap-book page about what's going on in my life and do some hidden journaling.

Interviewer: Okay.

Participant: Really count ... nobody else has to see it and then I just hide it away and then it's kind of a, I get to play with pretty paper but also get those feelings out. Yeah. I would say acupuncture. I go to acupuncture when I need it, so probably at least once a month I go and see an acupuncturist, and she's nice to talk to about those stresses as well.

Interviewer: Okay. That's great. I think you're the first person that's identified something like acupuncture that I've talked to. That's really great.

Participant: Yeah.

Interviewer: That's good. Okay, so a lot of expressive arts, a lot of things to get the feelings out.

Participant: Mm-hmm. I think talking with my supervisor is one of the best ways I feel like I'm able to continue to do the job that I'm doing. I have a lot of supervision. I have TF-CBT supervision, I have licensure supervision, I have a direct supervisor within my agency and all of that, and a lot of peer supervision with TF-CBT as well so I feel like I have so much opportunity to talk about what is frustrating me and help me to reframe things when I'm having a really bad day or I'm having a hard time with a client that supervision piece. I probably get more supervision now than I did when I was an MST counselor and in the field.

Interviewer: Okay. Wow. That is a lot of supervision. That was going to be sort of my next focus. We do know that counselor development tends to be facilitated by supervision so that's really good you've got different levels of supervision. You are working on the TF-CBT aspect and you're getting specific support and supervision around that skill set, but then you've got, it sounded like you said you've got an agency supervisor, a licensure supervisor, and then you have like a supervision support team?

Participant: Within TF-CBT we do peer supervision, and we dip into individual supervision with a consultant in that model. We also meet as a team and discuss issues biweekly.

Interviewer: You have a licensure supervisor. Is that supervisor employed by your agency, or is that outside of your organization?

Participant: He's contracted with our agency.

Interviewer: Okay.

Participant: It is a benefit of the agency that I work for and they pay for that and I signed a contract and all that good stuff.

Interviewer: Okay, but he's not employed ... he's contracted but he doesn't work for the agency?

Participant: No. He's worked for the agency on a contract level doing assessments previously, but he's not an employee of the agency.

Interviewer: Okay, so he doesn't have power to fire you, to hire people, to do that type of an evaluation?

Participant: No, nope.

Interviewer: Okay, so you get to keep -

Participant: I like.

Interviewer: Yeah, you get to keep those separate and you like that?

Participant: Yeah.

Interviewer: Okay. That's good. So anything else that you would say about your supervision?

Participant: Just like, in the early days, worrying that the supervision was going to be what I made of it. Sometimes, especially when they said, "This is who we contract with for supervision, if you want to find someone else you're welcome to find someone else and we'll go from there," and I was like, "No, we'll just do what you guys do already."

Interviewer: Because they paid for it?

Participant: Yeah, yeah. They were willing to pay for it as long as I could find somebody who was willing to take the money that they were going to offer, but I was just like I can't think of anybody off the top of my head, so let's try this. I think not knowing and being able to form a relationship with this person before, it wasn't like it was a professor that I'd had or somebody that I interacted with on a daily basis, it was just some random dude on a Skype screen that I met, that relationship, I think, has grown a lot over the last year and a half, and I definitely get more out of it now than I did before.

Interviewer: Okay, and you said it's a Skype session?

Participant: Mm-hmm. We've met a few times face to face, but he's in one city and I'm in another across the state.

Interviewer: Okay. So the distance is definitely an issue there.

Participant: Yeah.

Interviewer: Okay. All right. Then you have an organization supervisor, so someone who is responsible for evaluating you, but that doesn't impact your licensure?

Participant: Right.

Interviewer: Okay.

Participant: Yeah, so I get like internal supervision and yearly reviews and we meet weekly just to make sure that we're on the same page because there's a lot with the role that I'm in there's a lot of communication that could be a breakdown and a lot of frustrations that I feel like if I'm open with her about she can fix them because she's my supervisor whereas my licensure supervisor, he doesn't have any impact on my day to day job.

Interviewer: Okay. It sounds like a positive thing for you.

Participant: Yeah, yeah. I like supervision. I feel it when I don't get as much supervision.

Interviewer: Okay. Yeah, I mean we do-

Participant: It is another thing in the agenda, but I feel like it is beneficial.

Interviewer: Okay, good. Good. Anything else that you would say about your experiences as a counselor in the community mental health setting?

Participant: No, I mean, I've been in community mental health for 3 1/2 years because I was in it for several years before I started pursuing licensure. I've seen people come and go and I've seen people who are a good fit for community mental health and I've seen people who aren't and I think it just takes a lot of knowing yourself so that you know how to be successful in this type of counseling. Knowing that I'm okay if the phone rings after 5, but only up until, ... being able to create those boundaries beyond that.

Interviewer: Just taking care of yourself, putting up boundaries?

Participant: Yeah, that's all.

Interviewer: That's all. Okay. Well that's really good information. Trying to look through my questions to make sure I've hit everything I've needed to hit. It's very helpful and if you don't have anything else to say then I'll certainly let you get back to your life so I really appreciate your help with this study.

Participant: Yeah, it's great. Thanks.

Interviewer: Okay. I know a quick question that I need to ask you and you don't have to answer it. When I was looking over this survey, you didn't answer the age question? And if you don't want to answer it it's fine, but...

Participant: Oh no, I don't mind. It was probably an innocent mistake. I'm 29.

Interviewer: 29, okay. It's just helpful for me when I pool all the data together so I can have that.

Participant: All right, thank you.

Interviewer: Thanks so much.

Participant: Awesome.

Interviewer: All right.

Participant: Great, thanks.

Interviewer: Bye-bye.

Participant: Okay.

PARTICIPANT 9

Interviewer: I think we are set. Great. I'm going to go ahead and get started. I just wanted to begin by asking you to talk a little bit about your experience being a newer counselor in community mental health. That setting is particularly what I'm looking at. If you could just tell me about your job and role as a counselor in community mental health, and I know that we had emailed about this before, that you just started a new job. I want to know what that is, but I, also, really want you to be able to pull from those past experiences as well.

Participant: Are you ... You're mainly interested in North Carolina community mental health, because I did work before at a mental health clinic, and then I worked in my church for a while. But most recently, in North Carolina just for about nine months in a methadone clinic.

Interviewer: Let's pull from all of it. I think it's probably all valuable.

Participant: Well, my current job is as an outpatient therapist with a family preservation service organization. I do individual and group therapy with adults and kids. I just started that.
But the job I came from was "substance abuse counselor," trying to get my hands dirty at a methadone clinic, but it really ended up being more case management. I really didn't feel like I was doing counseling. I was just checking in with people on their drug screens, and on their medication dosages, and things of that nature. It didn't really feel like counseling.

Interviewer: Before that, when you were in more of a community setting, you said you were at a mental health clinic?

Participant: Clinic. Yes, a Christian counseling agency in Texas. I did what they called a residency. It was my first post-graduate job, as an LPC intern. That's what they call it in Texas, LPC intern. I did that for a while, and then I worked at my church, and had a hybrid role, but did some counseling for the members of the congregation and the community, as well, so folks from outside of the church. What would you like to know about?

Interviewer: Well, I think we'll get into more of the details here in just a minute, but that's helpful to hear some of the history that you bring to the study. I think that it sounds like all of those roles have been community. You're definitely touching community.

Participant: Yeah. And then at the counseling agency, I, also, worked with ... I just did something. Sorry. I worked, also, with at-risk kids in schools as a part of that job, but through different organizations. I was at middle schools and high schools in the area.

Interviewer: All right. You've done a lot of variety in the community. Wonderful. Good. I think we'll have some really good stuff to pull from then. I want to shift gears for just a moment, and let you know ... I want to talk a little bit about the survey that we did before. One of the things that researchers have found is that experience level, along with the setting of community mental health, can have an impact on our sense of professional

quality of life as counselors. That's one of the reasons that I had you take the professional quality of life scale as part of that survey.

Can you just talk a little bit about what your experience was like completing that very last portion, the professional quality of life scale, and if it brought up any thoughts or experiences for you?

Participant: Well, it was a little difficult because I felt like ... I didn't really feel like what I had done probably fit what was being asked. I was pretty disengaged in my last role. I was pretty unhappy in the role, and for various reasons pretty disengaged, so I felt like my answers were probably not typical, or would not be typical maybe for if I were in another job. I thought maybe I would have had maybe more vicarious trauma possibly, but I was so disengaged that I really didn't take anything home with me, and that wasn't necessarily a positive thing in that sense. In a lot of ways the reasons for why I wasn't taking it home may have been that I was just really disengaged.

Interviewer: It felt hard for you to answer some of those questions, because it didn't feel like it fit, but if you really think back about the work that you were doing, that scale addresses three different things. It addresses compassion satisfaction. It, also, addresses secondary traumatic stress and burnout. Thinking about compassion satisfaction, if you are bored, or you're not feeling like you're making much of a difference, that score could have been really low if you had taken that scale during your time there.

Participant: Right. I did relate more to those questions. I definitely felt like my compassion satisfaction was pretty low at that job.

Interviewer: Did it bring up any other thoughts for you, kind of thinking either about what you're about to go into or previous work?

Participant: Well, it made me a little ... And the concept is not new to me, but it did make me a little worried, like what do I have ahead of me in terms of vicarious trauma and things like that, and burnout? The agency I work for now is a very busy community mental health organization, and I get the impression that people work all the time. I'm anticipating the need for boundaries there and whatnot, which may not be easy to put in place.

Interviewer: Right. Even starting to look forward at your new role, thinking about how that may become an issue.

Participant: Right, exactly.

Interviewer: Well, good. Now you have a scale that you can actually go back to. If you just type in professional quality of life scale, you can have access to that for free, and you can download that, and make sure you're checking in with yourself on those things.

Participant: I mean I was, also, excited just that I'm going to be getting into some of that stuff more than I did in this last job, so part of it was anticipation of just, "Man, I have a real counseling job now. I'm going to understand more about some of this stuff." There was some positive to it.

Interviewer: Good. So, some hope about the potential for burnout and secondary trauma and stress.

Participant: No. I guess I mean more just being more in a position to even speak to these things that I'll actually be doing.

Interviewer: Absolutely, because that's what you trained for. That's what you were looking for is to get in there and do some work with people.

Participant: Exactly.

Interviewer: We know that it's a job hazard. Great. I'm going to shift back into community mental health information now. Can you tell me a little bit about why you choose to work in community mental health, so even thinking back as far as that first job, out of graduate school?

Participant: Well, honestly, that was just ... I went to school for counseling, but I didn't see myself becoming a therapist. I was doing it ... and I wanted to do ministry, and I just wanted to be in a better position to help people and to know how to better care for people, being a therapist. But when I got out of school, I didn't have any other path to go in terms of a job, and so I just started contacting different agencies back home to find out where I could do an internship (equivalent of LPCA), so that's how I got into that one.

Interviewer: It sounds like that's where the job was.

Participant: Yes. It was a program that actually had a ... It was like an internship program, specifically for people who had just gotten out of graduate school. There was a lot of supervision, a lot of training. It was very intensive. It was pretty miserable but it was a great learning experience.

Interviewer: You didn't necessarily choose it. It kind of was there, and it became an opportunity.

Participant: I mean I did choose it from among different options, but, yeah.

Interviewer: Do you think there was anything particularly appealing about community mental health?

Participant: I'm not a hundred percent sure I know what ... What's not community mental health? I mean obviously I guess private practice probably would not be considered community mental health, but what else would not be, because I'm not sure I'm fully understanding the term.

Interviewer: Sure. School counseling, of course, wouldn't be community counseling. Private practice, for sure, and then even things maybe like inpatient hospitalization could sort of be on the border of that, but I think the further we go nowadays, inpatient tends to be very community mental health.

Participant: I'm sorry. Would you remind me of your question, your last question?

Interviewer: Yeah. If there was anything in particular that was appealing about community work?

Participant: Let's see. With that job, it was more about the learning experience. They were offering a lot of support, and training, and supervision. But I liked the idea of working in the school with kids, at-risk kids, because I wanted

to help ... I have a heart for marginalized people, and just the needy, and whatnot. That appealed to me.

Then, now, honestly, to be perfectly honest, I think that's just where the jobs are in terms of my level. Part of me would like to get away from it, and just do private practice, and to be able to kind of create my job the way I want it, but it's not really an option for me at this level before I'm fully licensed.

I'd like to say that I still have all the idealism of I want to work with the poor and everything. Right now, I don't really identify with that feeling. It's more this is where the jobs are.

Interviewer: This is where the jobs are.

Participant: Yes.

Interviewer: Yeah.

Participant: At my level of not being fully licensed. Especially, my impression is here, you don't have a lot of options. You basically have your MCO, and your family preservation, and maybe one or two others, and if you can't get a job in one of those three to five places, or a methadone clinic, you're out of luck.

Interviewer: Yeah. I would say that your experience is probably very similar to others. That's part of this study, so thank you for saying that. That will get highlighted.

Participant: Bless the organization's heart.

Interviewer: Yeah. It's good that they hired you, right? So, kind of banking on some of that information here, I know that in community mental health organizations, there are very often additional job responsibilities. We may not get to just do direct client care, and help the people. Maybe some of that idealism ... Additional job responsibilities, things like paperwork or documentation, technology, insurance, Medicaid, all those kinds of things. Can you talk a little bit about your experience with those kinds of issues in community?

Participant: Sure. I'll speak to the last job I had, because that's more recent, and I can remember more. One of the reasons I didn't like that job is it was pretty much ... I mean it was hugely paperwork, and I felt like it was ... We had a fifty person caseload, and I felt like the whole system, which just designed to make you just kind of whip through people and just see them as fast as you could, and do all the paperwork that you had to do, the NCTOPPS, and the reassessment of some of the plans. There was just constant paperwork. Sessions were really about either just real basic checking in with people or paperwork.

Yeah. It was a huge ... I don't know what percentage of the job it was. Probably eighty percent. I don't know. Seventy-five percent it felt like. You just felt like you were just ... That's all you were doing pretty much. Then, I felt like I wasn't fully present with my patients. We called them patients there. Because you're so bent on, "Look, I get to get all this

paperwork done, and I've got to see this many people in a short amount of time," and just getting them through the door.

Interviewer: Yeah. You would say seventy-five percent paperwork.

Participant: I don't know if that's an educated guess, estimate. That may just be my feelings taking over, but I mean at least it's for sure fifty percent. Then when I was with the patients, I wasn't in counseling mode. It just wasn't counseling.

Interviewer: It wasn't counseling. There was a lot of additional ...

Participant: It was case management.

Interviewer: Case management, so a lot of additional responsibilities. Can you think back at all to your previous roles, if you can remember any of those other job duties?

Participant: In the church it was really laid back, so I wasn't being supervised by a licensed person at the church, and so they let me do things how I wanted to, and so I was pretty lax in terms of documentation, and paperwork, and stuff like that.

At the previous job before that, at the counseling center, there was a huge amount of policies, and procedures, and paperwork.

I felt pretty removed from that, and it feels like a long time ago, but I just remember it was extremely stressful. However, I do feel like I spent a lot of time with patients, and got a lot of really good direct experience. It was very different from this methadone clinic experience, which was just that the job felt like paperwork, with people kind of stuck on the end of it.

But the counseling agency job, I had a lot of direct client work, but I, also, had a ton of paperwork.

Interviewer: A ton of paperwork. Did you guys accept certain funding sources? Did you accept Medicaid, or other insurance?

Participant: We took insurance. I don't think we took ... I'm going by memory. I don't think we took Medicaid. We used a sliding scale. The clinic, we did not take Medicaid. And my current job, we do take Medicaid.

Interviewer: I know that you've just recently started, but are there any things that you can see already that are going to feel heavy?

Participant: Well, yeah, they've got me leading four groups ... They already told me I'm going to lead four groups, starting next week I think. In addition to taking on people's caseloads who are leaving, so I have a feeling I'm going to be dropped in, and it's going to be like bam, which is a good way to learn I guess, but ...

Interviewer: And you will be taking Medicaid?

Participant: Yeah. We have to ... Since I'm the LPCA and LCASA, I have to code it differently, but I can still see Medicaid patients.

Interviewer: Have they provided any kind of training on how to do the specific documentation for Medicaid billing?

Participant: They've started. We've talked a little bit about service definitions, but we haven't gotten very far into that yet. We were supposed to meet a few days

ago about that, and the supervisor had lost her cheat sheet, and needs ... She basically rescheduled the meeting for later in the week, so we haven't really gone there yet. I have some trepidation about, because I've looked at the service definition, and it's really complex, and pages and pages.

Interviewer: Yeah. And you've never really had to work off the service definitions.

Participant: No, I don't even really understand what a service definition is. I mean I kind of see what it's about, I don't have a strong grasp yet.

Interviewer: So, it feels a little bit overwhelming maybe, a lot of adjustment?

Participant: Yes, yeah, sure. Then, I know I've heard there's lots of other documentation, like you have to do authorization requests, and renewal requests for getting more hours for the patient, things like that. That's all new to me.

Interviewer: Do you know if you'll be responsible for doing the assessments, the comprehensive clinical assessments?

Participant: Yes. I will be doing walk in clinic assessments. I mean I'll be on a rotation.

Interviewer: You'll have ... I know the language pretty well. You'll have CCAs. You'll have person centered plans or treatment plans of some sort. You'll have to get service orders. You'll have authorizations, and then you'll have the Medicaid note.

Participant: Yes.

Interviewer: Lots of things to manage.

Participant: Yes.

Interviewer: It sounds like they haven't really even provided you with significant training, and next week they're going to ask you to do it.

Participant: Yeah. I'm not really clear on that. I got the impression we're starting next week, but I know more training is coming, and I'm just hoping it's going to be significant enough training before then, but I don't really know what to expect.

Interviewer: Kind of thinking back from the previous role, and then even before, thinking about some of those additional responsibilities and paperwork, how do you see that those impacted your ability to actually be with your clients to do counseling work?

Participant: Yeah. I tend to be pretty task focused, and if there's a lot of paperwork and stuff, I get very absorbed with the task and needing to cross things off of a list, and it can kind of take over for me, where I feel like my goal is just to get through the paperwork and whatnot. I felt like it took away from my client focus, because that did not seem to be the priority. The priority seemed to be crossing a lot of T's and dotting all our I's. I found myself always rushing, feeling this constant sense that I had to rush all the time, and rush through my client sessions, because that just ... I don't even know how to explain why that was, but it felt like you're always behind the eight ball, and have all this paperwork to do. I just couldn't put

my heart into the client work. I didn't say that very well, but I think you know what I mean.

Interviewer: Yeah. You would get very task focused.

Participant: Yes.

Interviewer: Very attention toward the details of the paperwork and getting all that done, as opposed to spending the time with your client.

Participant: Right. I didn't feel like there was space, psychological space for that. I don't know how better to describe it. Because there was just all this other stuff that had to get done. It's stifling.

Interviewer: Not space ... When you're with your client, you're actually thinking about the paperwork, and how that needs to be done.

Participant: Yeah. Or that I need to get X number of people seen, because we have monthly requirements and you had to see your client load a certain number of times per month, and then within that you had to make sure you'd gotten their treatment plans updated, their NCTOPPS updated, all of these different things. It just became a lot of transactional stuff.

Interviewer: Thinking back across your lots of different variety of experience here, can you describe some of the types of clients and client issues that you have experienced working with in the community setting?

Participant: I mean a little bit of everything I think, but not a lot of any one thing. Obviously, a lot of depression, anxiety, things like that, bipolar disorder. Then I had things that I just saw one time each, like gender identity disorder. I had maybe one or two eating disorder type situations, but we try to generally refer that kind of thing out. The methadone clinic, it was substance abuse was the primary thing, but a lot of ... just a ton of co-occurring mental health ... Mental illness, co-occurring mental ... You know what I'm trying to say. Mental illness diagnoses or undiagnosed. Then dealing with a lot of social issues as well. A lot of poverty, a lot of poor resources, poor supports. Back when I worked at the mental health clinic, I just remember ... It's been a long time, but I remember I just felt like I had a little bit of everything. Sexual abuse, drug addiction. What else?

Interviewer: Yeah. I was looking through that checklist that I know I had, and I see a lot checked off here.

Participant: If you want to ask me specifically about some of those, I could tell you if I've actually seen somebody.

Interviewer: Yeah. I mean I'm wondering about ... You said poverty, so one of the things that I have heard come up is homelessness.

Participant: Yes.

Interviewer: You've worked with that?

Participant: I have homeless clients, and not that I necessarily did a whole lot about that. At the clinic, it was just one of their issues I knew was there.

Probably just a couple, two or three patients I knew of who were homeless in that job.

Interviewer: The other one that I see is trauma, different types of trauma, of course. Sexual trauma, but other interpersonal traumas.

Participant: Yes. I mean I guess the majority of the population I worked with at the methadone clinic had trauma histories. In the family preservation, they're trying to become a trauma informed organization, and I'm pretty sure from the online learning I've been doing on that that most people I see are going to have some trauma.

Interviewer: You're kind of anticipating that.

Participant: Yeah.

Interviewer: Let's see. Some of the other ones. Housing and homelessness, and domestic violence, things like that.

Participant: Yeah. I'm not sure I've ever worked with someone where that was a presenting issue that I recall. Maybe back in the counseling center that I worked at at the very beginning. No. Because I think I would remember referring them to resources, or trying to get them into a safe place and things like that. I think that was just one that I was expecting I would be dealing with.

I'm sure there were plenty of people who I saw who probably had that in their history, but I wasn't aware.

Interviewer: Things like depression and anxiety come to mind. You said that earlier, so suicide, or self-injury, or some other kind of crisis kind of comes to my mind if you're working with depression in particular.

Participant: Yeah. People who cut. Suicidal ideation in the past. Not a lot of current high risk there.

Interviewer: You have not had a lot of high-risk clients?

Participant: I haven't had to call in local crisis or anything like that thus far.

Interviewer: Good.

Participant: Yeah. I've gotten lucky on that I guess so far.

Interviewer: Yeah. Definitely ...

Participant: People who said they've had suicidal ideation in the past, or have had attempts in the past.

Interviewer: It sounds like going forward you'll maybe have a little more exposure to that sort of crisis mentality. Just something to look forward to.

Participant: Yeah.

Interviewer: Kind of thinking about those types of clients and client issues that you have experience with, can you think about how some of those hard things that you discussed have impacted you both professionally and personally?

Participant: Yes. That's kind of where I had the hardest time on the questionnaire is I'm not really aware of having ... I feel like my boundaries have gotten a lot better since ... I'm sorry. I've changed my position. I'm doing a Skype with you. I forgot what I was doing.

It seems like in my earlier days, not that it was that long ago, I felt like I had a harder time with boundaries than I do now. I feel like I'm a lot better at just letting things go, and just separating my work from my personal life.

But I, also, wonder, like I said, whether some of that was not disengagement, not being super engaged with my clients. But I do remember when I worked at the mental health agency dealing with some pretty ugly, yucky situations, like a thirteen year old who had been raped. I know that stuff bothered me. I don't remember any specifics about how it affected me, but I'm sure it did.

But in this clinic job, it was kind of like I just wanted to leave when my day was up, and I kind of put it behind me until the next day.

Interviewer: Again, that disengagement, which ... Yeah. Disengagement, which probably means lower compassion satisfaction for you, so not really getting a lot of fulfillment out of the job. Not so much traumatic stress or burnout from working with difficult issues, but not enjoying the work.

Participant: Right. The burnout was more from just paperwork and trying to keep up with requirements, but not so much emotional burnout.

Interviewer: Believe it or not, that's where we tend to burnout most anyway, is not with our client issues. We burnout with all of the documentation and paperwork, so you're right on track.

Participant: But I'm sure I'll have to be a lot more careful about that in this current job.

Interviewer: Yeah. The more severe client crises and client issues, that tends to sort of tug at your own heartstrings and your own desires to help, so that compassion satisfaction could be a little more hard to manage.

Participant: Right.

Interviewer: Kind of thinking about all of these things, how do you deal with stress or self-care?

Participant: I'm not great at it. I'm learning. I think I'm better in some ways than I used to be, but I'm terrible about exercising, which is something I know that I need to do, and I don't do a good job of keeping up with that. I'm better at quiet time and alone time, just refueling. I have spiritual practices that are very important to me. It makes a huge difference to me if I have a devotional in the morning versus the day that I don't. My resilience is so much better when I do that and when I'm praying for strength and for courage and for energy and all that.

Interviewer: Spirituality is a big thing that you really see as central to your self-care?

Participant: Yes, definitely. I don't do a good job of a lot of the traditional self-care means, like eating right. Sleeping, I think I mostly get enough sleep, so I do okay with that, but eating and exercise, terribly. I know there's lots of other self-care stuff, but social, I think I do enough social engagement. I could do more, but I do have some regular social engagements.

What else? What else am I missing on that self-care? I mean I know there's any number of things. Did I answer your question?

Interviewer: You did. You did. Kind of thinking about all we just talked about, can you talk a little bit about maybe what you think prepared you for your work as a counselor?

Participant: Sometimes I don't feel very prepared. I've dealt with a lot of anxiety with this new job starting. I deal with pathological anxiety. I have a diagnosis, and I take medication and everything.
But just ... I feel intimidated by it. I feel sort of like I wasn't prepared. I'm not sure my program prepared me adequately, and deal with a lot of insecurity issues, and wondering if I'm going to be competent, things like that.
What did prepare me? I think just life experience. I've gone through plenty of my own struggles, and so I think I bring that to bear with clients. I think that I'm ... You're not exactly asking what my strengths are, but it's sort of similar, right?

Interviewer: Yeah. What you feel prepared you to come to deal with all of the issues that we face as counselors, yeah.

Participant: I just am very fascinated by human problems and human relationships, and so that's huge. I had a really good graduate program. I don't feel like it prepared me very well for the real practical stuff, like the actual skills. It was more theoretical. I feel a little like that it didn't quite give me what I needed in terms of the more practical stuff, but I have a good underpinning for everything.
I feel like I'm really good at just making people comfortable, and helping them trust me, and whatnot, so I think developing those skills has prepared me to be a counselor.
Let's see. What else prepared me? Just my desire to help people and to minister to people.

Interviewer: So, the interest and just being fascinated by it seems to keep you engaged.

Participant: Yeah. And the learning experience. I love to learn about human issues.

Interviewer: Great. These are great answers. We're kind of shifting gears one last time here. We tend to think that counselor development is often facilitated by supervision. It's, also, a requirement as an LPCA, so I'm wondering if you can talk a little bit about what your experience with supervision has been.

Participant: Kind of mixed bag. I had really good supervision in the earlier days when I was in that training program, that residency program. My supervisor really held me to task about bringing cases, and really talking through them, and got lots of help on specific cases, as well as dealing with just general stuff like anxiety and whatnot.
My most recent supervision experience, I felt like was not a good experience, but part of it was I didn't feel like I had anything to bring from the clinic, because I didn't feel like ... My tapes were me saying, "So, how are you doing at a hundred and twenty milligrams?" "You failed your last drug screen." There wasn't a lot of material, so she didn't have a lot to work with, but I, also, feel like she was pretty hands off, pretty

undirective, and I could have used a little more direction and supervision, so it felt like I was just paying ... She's actually a very well respected supervisor, so I think part of the problem was me, and me not being as prepared as I should have been for supervision, and being disengaged, and then not having a lot to work with because of the methadone clinic. But, also, I felt like she was pretty hands off, and I felt like I was just paying to check something off my list.

Interviewer: In the past, you've had really intense supervision that was on site, where you knew you were getting it. You were getting training, and that was a good experience.

Then, you've had ... At the clinic, was your supervisor part of the clinic, or was she off site?

Participant: No. I went to an offsite supervisor.

Interviewer: It was not included.

Participant: No. No, I had to pay for it.

Interviewer: You had to pay for it. Now, were you reimbursed for it?

Participant: No. Now, at my new job, it's covered. It's internal. But that job it was out of pocket.

Interviewer: Kind of thinking about positive and negative components of supervision, specifically I guess I'm asking more about do you see benefits or maybe disadvantages of the types of supervision? So, having an onsite versus an offsite supervisor, those kinds of things?

Participant: Sure. I think on site has been most successful in my experience. In grad school I had a supervisor that was sort of on site, and then post-grad, the onsite supervisors. I mean they knew exactly what I was doing. They knew how to ... I mean it just made for much more engaged supervision. In this one, this most recent was removed from that, and she has her own opinions about my setting, too. Sometimes that wasn't always helpful. Yeah. I think it would have been a lot better if I had had an internal supervisor, who knew this kind of stuff I was dealing with, and could tailor supervision for that context better than she was able to do.

Interviewer: The onsite supervision for you seems to work best.

Participant: Yes. Definitely not having to pay for it is huge, because I was paying ... She was actually cheaper than a lot of people, because she was trying to help us, because she knew that none of us had very high paying jobs, but I still was paying two hundred dollars a month for it, fifty dollars a session. Some people charged twice that much.

Interviewer: Right. That seems like a real burden on newer counselors, especially that associate license; you're not making a lot of money.

Participant: Right. It may be prohibitive. There were times when I thought I was going to have to figure out a way to quit supervision. I was going to have to take a hiatus with the board, because I did not think I could pay for it. I was able to figure out a way, but it was really a question there at different points as to whether I could continue.

Interviewer: Even it could have, at some point, contributed to either leaving the field, or at least stepping away in a different way.

Participant: Yeah, or taking a break and just getting some job to get a job.

Interviewer: Anything else that you would say about supervision in the community based setting?

Participant: No. I know how important it is for me to invest in it, and to be prepared, and to come with cases and whatnot, so I'm looking forward to taking a lot better advantage of it now. Now that I'm not paying for it, that helps.

Interviewer: That helps, yeah. Now, your supervisor at this current job, I know she's on site. Is she, also, your supervisor supervisor? Like your manager?

Participant: She is not. She's somebody that was connected with a company. She's been connected with a company for years in different management positions, but now it's just a supervisor, so she just comes to campus to do supervision.

Interviewer: So, she doesn't have authority for hiring and firing kinds of decisions.

Participant: Right, no. I mean not as far as I know.

Interviewer: Great. Well, this has been really helpful. I really do appreciate you taking the time. I got some really great information.

Participant: Good. I just was feeling like I wasn't going to be able to be able to be very helpful. [Inaudible 00:39:21] I've been so ... Yeah. I just feel like ... I don't know. I have more questions than answers about anything these days it feels like.

Interviewer: Sure. Yeah. You really were helpful, and I got some really good information I think that will be very useful, so I truly appreciate it.

Participant: You're welcome.

PARTICIPANT 10

Interviewer: Thank you for doing all of this. I got your results from the survey so I appreciate you doing that. For some reason, one of the questions that people keep missing is the age question. It's okay if you don't want to answer it but I think there must be something with the survey. Would you mind sharing your age?

Participant: Forty-three.

Interviewer: Thank you.

Participant: Yeah, I didn't even see it.

Interviewer: A lot of people have missed it so it must be something about the design of the survey that people are missing it. No big deal. No big deal.

Participant: Yeah.

Interviewer: Great. All right. I know you have a lot of experiences in mental health so we're going to pull on probably a lot of those but I want to focus mainly on community mental health settings,. To get started I just want to learn a little bit about your experience overall as being an entry level counselor in the community mental health setting. Can you tell me about your current job and role as a counselor?

Participant: It's for a small mental health agency for adolescents, generally ages twelve to about eighteen. There are some foster ... I see kids in the group home. I also see kids in foster homes so I have probably one or two eighteen or nineteen-year-olds but it's about twelve or thirteen total.

Interviewer: All right. What is your job title?

Participant: Well therapist, ...because I also supervise one of the houses and I also work in a group home so kind of a combination, but it's mostly therapist.

Interviewer: Okay so therapist. You said group home so there is a residential component to it?

Participant: Yes.

Interviewer: Is it one hundred percent residential?

Participant: No.

Interviewer: Okay so it's community based or outpatient?

Participant: Yeah, it's probably about half of mine are group home, half are in foster homes.

Interviewer: Great. That's helpful. All right so to go back to the survey portion that you completed one of the things we found as researchers that experience level and also setting tends to impact our sense of professional quality of life. I had you complete the professional quality of life scale as part of that survey and I wanted if you could just talk to me a bit about your experience completing that survey. Did it bring up any thoughts or feelings for you?

Participant: Well probably one. It's probably a perverse thought is I checked off a lot of things that didn't bother me and it almost seemed like some of them should have. I guess this was a bit of a thing that I had going through grad school is it seemed like I didn't care enough because I could separate things. That seemed a little odd, but I mean that's just the way it is. Things don't bug me. I don't take it home.

Interviewer: Okay so you feel like it pointed out for your ability to separate work from your personal life?

Participant: I think so, yeah. Yeah, I mean the biggest part where it gets confusing is trying to manage the two and the timing.

Interviewer: Yeah, that makes sense. All right, so it didn't really bring up a whole lot for you. Any other feedback or thoughts that you had while you were taking the survey?

Participant: No, it was pretty simple and straightforward.

Interviewer: Great. Great. I know that you have a few other pieces of your counseling history. I know you spent some time in school and it looks like you did some juvenile justice kinds of things. Can you tell me a little bit about why you chose to work in community mental health?

Participant: I think way back when I was first thinking about getting my degree that's what I wanted to do. I don't know it just always seemed like something I was doing anyway with the people and everybody seemed to always want to discuss stuff with me and that's the direction I was going in.

My wife convinced me to go the guidance counselor route because that's what she was and it would have been easy to coordinate schedules and stuff like that. We would have had the same time off and all of that sort of stuff, so I went that way. I always liked me talking to the kids more than doing the paperwork. I liked the job but not as much as I think I do now.

Interviewer: You first went into school counseling and part of that felt like a good idea because of your schedule and you found yourself liking the work with the kids as opposed to some of that ...

Participant: Right.

Interviewer: ... paperwork intensive so it looks like you made a shift, made a change towards community.

Participant: Yep.

Interviewer: Yeah and what do you think draws you to community? You mentioned the interaction but what else?

Participant: It just seems more productive and more useful I think than just sitting there and filling out schedules and paperwork and graduation requirements and all that sort of stuff. It's useful, but it doesn't seem like it's getting to anything. The only time I really felt like I was doing anything was when the kids actually had problems. We're not really supposed to talk to them about stuff like that because it's not really set up for that.

Interviewer: It sounds like that work was not as fulfilling and you wanted something more. You wanted something a little deeper with more substance.

Participant: Yeah. Something where the talking part was the focus, not something I had to squeeze in.

Interviewer: I noticed that you are part of ... I know you're in a... Is it nonprofit or for profit?

Participant: For profit.

Interviewer: For profit community agency but it looks like you guys do a lot of public funding.

Participant: As far as I know. They get a lot of Medicaid and a lot of, I believe it's the other IPRS funding. I'm not quite sure. I know I've heard people talking about it. That seems to be an issue with getting the funding.

Interviewer: Is there any particular pull towards this specific type of work that you're doing with adolescents?

Participant: Probably, I mean I've always thought that if you can catch them younger you might have a better outcome, maybe I'm right, maybe I'm wrong. I think I tend to like the older adolescents and the early adults. It's because they can talk more rationally or more concretely.

Interviewer: Yeah, so that population it feels good that you might be able to catch some of those problems earlier than later.

Participant: Yeah.

Interviewer: Then you like the way that they are able to talk about their problems.

Participant: Yeah.

Interviewer: Great. Moving in a little bit of a different direction, one of the things we know in community mental health settings that often there are lots of other additional responsibilities besides client care so things such as paperwork, documentation, working with certain types of technology, billing, different types of compliance issues that might be put on the organization. Can you talk to me a little bit about what your experience of that sort of thing has been in the community setting?

Participant: It hasn't been too bad. I do some assessments. I supervise the group home. I'm responsible for ... I don't oversee it in terms of management, but making sure stuff gets done so I guess more of a compliance thing so it takes up some time not a great deal, not a huge amount, you know the documentation that goes along with it, but probably the assessments and stuff and that sort of stuff probably takes up more time.

Interviewer: You do some compliance, just making sure everything is in order, but you also do assessments for the kids.

Participant: Yeah.

Interviewer: Is that generally a Medicaid CCA format?

Participant: Yeah. I believe so.

Interviewer: Are you responsible for authorizations or billing?

Participant: No.

Interviewer: No.

Participant: I stay as far away from that as I can.

Interviewer: It sounds like they've set you up so you don't have to deal with that kind of thing.

Participant: Right, yeah. There's other people that do that.

Interviewer: Okay, so you have maybe a department or other people that help out with the authorization and the billing piece of it?

Participant: Yep.

Interviewer: That's good. You don't have to deal with the financial piece of it but you have to do the paperwork to get the financial piece approved probably.

Participant: Yes, I have to do that and I have to make sure the notes are in so they can bill for it and then document my time and all that sort of stuff. Just as long as I do that background work, somebody else handles the billing aspect.

Interviewer: All right. Good, so somebody else can deal with that piece of it. How much time would you say you spend doing some of those other responsibilities, paperwork related?

Participant: Probably it's less than half the time, I think, probably well not by much though probably forty percent.

Interviewer: Forty percent?

Participant: Yeah. I mean it could be more if I took more time doing things I guess. It's something I compress as much as I can to spend more time doing the other stuff. Yeah, it's probably about thirty-five, forty percent I would say.

Interviewer: Thinking about that, you said you compress it so that you can spend more time doing the other stuff, how do you see some of that paperwork and

additional administrative piece impacting your ability to work with clients?

Participant: It's good and bad. I mean at least doing the documentation stuff like that I remember things so next time I talk to them I can remember use it to reference to go back and discuss things we've already discussed. The assessments if I do them the way I like to do them I get more information than some of the ones that I've seen previously that had almost nothing on them. I get more information than I had.

Sometimes the formats seem, to be polite, incomprehensible, but they duplicate themselves and you've got to put things in multiple places. You've got to break things up in an unnatural kind of format, stuff like that. It's more stylistic than anything else.

Interviewer: Yeah, so sometimes you see these documentation pieces as helpful because you get information. It helps you keep track of what is happening with your clients but on the other side of that it can sometimes be illogical in it doesn't fit, it doesn't flow.

Participant: Right, yeah. Sometimes it seems a little inefficient in the way it's done.

Interviewer: Inefficient.

Participant: Yeah.

Interviewer: That's a great word for that. It can sometimes get in the way then of doing work with the direct care of your clients?

Participant: Yeah, I think so because I go back and forth between do I do it right after I talk to them or do I you know because I like to just go on to the next thing and do the next thing and sometimes I get behind. Then you've got to go back and have a marathon session of getting everything done which I don't really like, so I guess I don't like to do it because it seems like it isn't really the prime focus but I know that if you didn't write it didn't happen so it has to be done, but I just would prefer to move on to the next thing to deal with.

Interviewer: Well great, so shifting gears a little bit here can you describe a little bit to me about the types of clients that you see and client issues that you work with in this setting? I know you narrowed it down to adolescents and it sounds like foster care issues and things like that but could you expand a bit on what types of client issues you see?

Participant: Most of it is conduct and behavioral, ODD type, anger management, substance abuse, some PTSD you know trauma, minor amounts of anxiety, some depression but mostly the ODD, ADHD that sort of stuff, conduct disorder.

Interviewer: Yeah, so a lot of behavioral things but you also say trauma. If you had to put a percentage on the trauma, what would you say?

Participant: I'm trying to think of what I put down. I thought it was about ten, maybe ten, maybe fifteen percent, somewhere thereabouts].

Interviewer: Yeah, it looks like child abuse you put about ten percent.

Participant: Yeah, and I think if I remember the kids that I have the abuse neglect is probably the primary trauma that they seem to have gone through and it's probably a couple of them out of the twelve or thirteen.

Interviewer: Yeah, so mostly behavioral things, not so much trauma.

Participant: Right. Yeah.

Interviewer: All right. Some of that can I'm sure be difficult. You started to talk a little bit about how you can separate your work issues. Can you maybe talk a little bit more about how some of those issues that your clients face might impact you professionally and personally?

Participant: Some of the stories can seem pretty unbelievable and remarkable at the same time because some of the things that the kids say they've gone through you just wonder how they're still functioning at all. I think I tend more to be in it because I grew up with very strict parents so it was very good and bad punishment based sort of thing. I think that's my natural tendency just to be a little firm but when I hear these I back off a bit and realize that that's not going to work. It adjusts how I do things.

Interviewer: Yeah, so adjust from your personal experiences to incorporate their experiences and maybe even traumas or really difficult things they've experienced?

Participant: Right.

Interviewer: You just don't feel like you take very much of your work with you though. It doesn't seem to follow you into your personal life?

Participant: I don't think so. The specifics with the kids I mean sometimes it's a frustrating day when you don't get anything done or you don't get done what you want to get done or something happens that you couldn't account for so maybe some of that, just the frustrations, daily frustrations kind of thing but in terms of specific things that kids talk about no.

Interviewer: No.

Participant: I mean it's not saying I don't ever think about it but I almost think about it more in a way of what can we do about.

Interviewer: Okay so thinking about it more of a productive kind of thing?

Participant: Yeah.

Interviewer: All right. Anything else that you could think of that you would like to share about client issues, things that you see on a regular basis that might be impactful?

Participant: No, I think probably the biggest thing is a lot of them come here that are not coming here voluntarily so a lot of them think they don't have a problem and can be reluctant to discuss anything so it takes a little while to get them going. That may be different from a more community-based setting where they come in generally voluntarily. You have to get them to at least recognize there's an issue first before you can do anything about it.

Interviewer: Yeah, so maybe part of it is the involuntary piece that they're not necessarily willing to be open about their issues because they don't think they have issues.

Participant: Right, yeah pretty much.

Interviewer: That can be a challenge for sure.

Participant: Yes.

Interviewer: That's good. That's good information. Even though you say it doesn't seem to impact you I'm wondering about self care, I'm wondering about how you deal with stress management because that's just a human thing. We all have stress and we all need self care.

Participant: Probably not too well. I mean I try and exercise. I like to do yoga, the Tai Chi and meditation stuff like that so I have all that. I'm not too consistent with it. I go up and down and back and forth. I have a lot of stuff I've got to do here. Then I have a challenging family life to say the least so I tend to spend more of my time doing stuff for everybody else, not so much thing. I have to sneak in times to read or to relax or to do things so it's not as consistent as it needs to be.

Interviewer: Consistency with self care, you have some of the skills, you have some of the things that you know you like to do but it's tough to get them in?

Participant: Right, yeah. Somebody else's crises always seems to take precedence.

Interviewer: We're good at that as counselors, aren't we?

Participant: Yeah.

Interviewer: Well tell me a little bit about what you think might have prepared you to deal with some of the stressful things as a counselor.

Participant: I have no idea. It's not like I can point to any traumatic childhood. I didn't like it but it wasn't that bad, so how I can just wall things off, I don't know. I really don't. I mean it's something I for the most part have always been able to do, just care in the moment but once it's over with just let it go. I really have no idea. I really don't.

Interviewer: It sounds like some of this is just your personality. You're just given to caring for other people and being able to separate that from your own self. I'm wondering though if you could think back to graduate school or any other experiences that might have prepared you to be a counselor.

Participant: I mean it was probably before that because I ended up with psychology. I mean I guess just the way I grew up where the standards were very high and if we weren't successful there's were always questions as to why and never seemed good enough kind of stuff. I might have just decided that I wasn't going to take in too much of what somebody else was saying. I think I'm not as good at it then as I am know because I've had time and age and experience to just pick up extra ability. It might have been just from that. I've always been the kind of person that's alone. I'm not an outgoing type of person so that probably helps. I tend to pick up and drop things, hobbies and things like that fairly quickly so that might help as well. I pick up an interest and then once I finish with it I move on. It's possible it's from the way I grew just the way the lessons that I took from how my parents interacted, whether or not that's what they were intending that's what I accepted from it. I mean that's

possible. That's the only thing I can think of because there's nothing concrete that I can recall.

Interviewer: All right, so nothing even from training, just it seems like from life experiences?

Participant: Yeah, I mean I've had some of the training but by the time I had it it may have just been fine tuning what I already did. I don't know maybe I just don't care. I don't and I've never really gotten overly got excited about things. I'm not an overly emotional type of person so it's just it's easy to let things slide.

I started reading a couple of years ago about the mindfulness type stuff and that I think finally put a name on it. I've read a fair amount of it and that seems to be the way I go where it's like stuff happens. You can be upset about it or you can just deal with and move on. I think the training reinforced what was already there.

Interviewer: That's a good way to look at it. The training reinforced what's already there. Yeah, I like that phrase. To move into a very different direction here at the end of this process thinking about supervision we tend to believe that counselor development is facilitated in one way by supervision. We also know it's also a requirement for professional counselors looking for that full licensure so I'm wondering if you can describe a little bit about your supervision experiences in general.

Participant: It's decent. It's actually fairly informal because I'm here and the supervisor is here. We started out setting a specific time but then one or the other of us always had something to do so it's maybe not ideal from the I guess clinical or best practice perspective where you sit down and you have a time blocked out but you have a walk-in and discuss things kind of thing. That's the way I tend to like things anyway. I don't like to put things on a shelf until a week later because if it's something that's bugging I like to get it dealt with because I need it dealt with right then and not on Friday so it suits my ... I think I have ADHD so it suits my nature to do things as they come along and it's probably at least about an hour week.

Interviewer: Okay, so at least an hour a week which that's the requirement.

Participant: If I added it all up it's probably closer to two but I think you only really get credit for one.

Interviewer: True. That is true. Supervision for you is included as part of your job.

Participant: Right.

Interviewer: The supervisor is there on site so I'm assuming you don't have to pay for it. It is included, right?

Participant: Right. Yeah.

Interviewer: You really like this information style of it. When something comes up, you can go right to your supervisor.

Participant: Right, yeah because I don't like to find out a week later that I did something wrong and screwed something up and said something I

shouldn't of and possibly made it worse so I just like to deal with it right then and there.

Interviewer: Okay, so it gives you that immediate feedback. It gives you that checking it out right then.

Participant: Yeah.

Interviewer: What other kinds of things would you describe about your supervision other than informal?

Participant: I guess if I wanted to use a buzz word it would be collaborative because it's not just me coming for information. It's a back and forth. I don't know everything and neither does he, so if I can find out some resource or some way of doing something or some way of looking at something that he hadn't thought of or known about before then it goes both ways.

Interviewer: Okay so collaborative. You work with each other.

Participant: Yeah.

Interviewer: Now your supervisor on site there is he an administrative supervisor as well so does he have the ability to fire and evaluate?

Participant: He's clinical director so I think evaluation is part of it. I don't know about hiring and firing. I think he's part of the process, but doesn't have the final say.

Interviewer: Doesn't have the final say, okay. Would you say that any of that knowing that he's the clinical director and has maybe some say at least in part does that bring any different dynamic to your supervision?

Participant: No, I don't think so. You mean in terms of like concern about a power differential or anything like that?

Interviewer: Yeah.

Participant: No, I don't think so and maybe that's just part of my personality. I don't get intimidated by that very often. I've been in the military. I've been around generals and high ranking people. I think I tend to be a little casual about stuff like that. I guess, how do I want to put it, maybe a tad disrespectful just because I don't act the way people probably expect when there's that kind of difference but that sort of thing just doesn't bother.

Interviewer: All right, so it doesn't create an environment where you can't bring issues or problems that you feel like you're having or insecurities with your clients.

Participant: Not at all.

Interviewer: Good. Good. Maybe just give me a little more information, any positive experiences or negative experiences with supervision that you've had even if it's been at a previous role maybe.

Participant: I mean this has been pretty much nothing but positive. I have had bad in other jobs, different jobs I've had good and bad supervisors. The ones that were bad are the ones that didn't really listen that considered themselves better than everybody else because they were supervisor and never had problems like this when they were doing it. I guess a little too imperial or dictatorial because they were in charge and you weren't, you know didn't

want to listen. That's over the years probably have had that a number of times. Just wait it out.

Interviewer: Okay, so just wait it out. There's going to be positives and negatives.

Participant: Yeah. It's good, bad same as everything else. The last job I had I had three or four different supervisors because I moved around and if I didn't like one of them then if I waited long enough I would get a different one, so nothing's permanent. You try not to get annoyed by it.

Interviewer: Try not to get annoyed by it, yeah. That pretty much sums up my interview questions. Is there anything else that came to your mind as we were talking through this set of questions?

Participant: There was something but I can't remember what it was. I think it's just more of ... There was something about just being able to let things go but I can't remember what it is now so it's ...

Interviewer: Yeah, that's fine.

Participant: Yeah. Sorry.

Interviewer: That's fine. That's fine. I definitely appreciate your time. This has been really helpful.

Participant: This is the first time I've done this too. I usually never qualify for these things.

Interviewer: Really?

Participant: Yeah. Yeah, I either have too much or too little or in the wrong and that kind of thing.

Interviewer: Well I'm glad that you qualified.

Participant: Yeah, it was fun believe it or not.

Interviewer: Great. Thank you so much Participant. I really do appreciate your time. If you ever need anything, don't hesitate to reach out. I'm here in the Greensboro area. Then you'll be receiving your fifteen dollar gift card to amazon.com here shortly.

Participant: Okay.

Interviewer: All right. Thank you.

Participant: All right. Thank you.

Interviewer: All right. Bye-bye.

Participant: Bye.

PARTICIPANT 11

Interviewer: OK. I sent you the survey link, and I got your information, so thank you for completing that. And then, I also sent you the questions for the interview portion. I don't know if you had a chance to just kind of look through those.

Participant: Yes.

Interviewer: OK, so you kind of know where we're going, what I'm going to be asking.

Participant: Mmm hmm (affirmative).

Interviewer: Great. OK. Well, so to get started, I just want to learn a little bit about your experiences as an entry level- got it?

Participant: I'm trying to adjust. I see me but I'm small, and I see you. Do you see me?

Interviewer: I see you.

Participant: OK.

Interviewer: You are- on your screen, you should be small. And on your screen, I should be big.

Participant: OK, got it.

Interviewer: So that way you can see yourself, but the focus is the person you're talking to.

Participant: Got it.

Interviewer: Yeah. Very cool. You'll get the hang of it, and then you won't be able to stop yourself from skyping. So much fun. All right. If you could just start by telling me a little bit about your experience as an entry level counselor in community mental health. So tell me about your current job, your current role as a counselor.

Participant: OK.

Interviewer: Yeah.

Participant: Right now, I am an LPCA working at a community agency. I work there. I have about 15 clients, and I see them 6 days a week. I learned of the agency ... the owner came through the doctoral program at a school near me. She has formulated her own mental health agency. I really like it. It's a very flexible experience, more flexible than my previous agency that I was working for. I see clients in the home, in the local areas.

Interviewer: OK, what's your title?

Participant: Licensed Professional Counselor Associate.

Interviewer: OK, so that's what they call you at your organization, even?

Participant: Mmm hmm (affirmative).

Interviewer: And so, your role is to do in home counseling with the clients?

Participant: Yes. Outpatient, in home. It's individual. It's not a treatment team.

Interviewer: OK, so it's not a treatment team. It's individual. So this is not intensive, in home, or MST or any of those kinds of things. This is pure individual outpatient.

Participant: Yes.

Interviewer: OK, but you get to do this in the client's home, so you kind of get to meet them where they are.

Participant: Yes.

Interviewer: All right. Very neat. I would say that I haven't heard very many models of just individual therapy being done in the home, so that's really interesting.

Participant: It is. I like it. I've never done the treatment team model. I've never done intensive in home, I've never done MST. This is all I know. Even at my last agency, it was primarily OPT. I do like it, because it puts a concentrated effort on the client when they don't have as many emotional issues as a person would who needs intensive in home. These clients don't need a treatment team. It's basic adjustment issues, low mood, depression,

ADHD. It's not, you know, concurring issues on top of one another that require a full team.

Interviewer: I think I noticed in the survey that you noted it's pretty much 100% medicaid funded?

Participant: Mmm hmm (affirmative).

Interviewer: OK. OK. So that's really neat. I'm interested to hear about this, this model, because I don't think you usually hear that more supportive counseling in home. So-

Participant: Right, right.

Interviewer: This is great. This is great. OK. And you- I think you had noted that you have been there for a while but you also had held a previous position?

Participant: Mmm hmm (affirmative). Before that I was at a- I spent a year at another community mental health agency, also located here in this city. Maybe not a full year, I think it was actually 9 months.

Interviewer: But it was kind of similar, it was still doing outpatient?

Participant: Mmm hmm (affirmative). Very similar. It was a primarily Spanish speaking population, and I knew a very little bit of Spanish. I took it for a few years, but ... We had to have an interpreter sometimes to go with us to the homes, and there was a lot more family involvement and kind of a little bit of a social work component, due to the population. It wasn't really strictly counseling, so to speak.

Interviewer: It sounds like maybe there was a little bit more case management involved in that position.

Participant: Right, right.

Interviewer: As we talk from this point on, I do want you to feel able to pull from both jobs, just kind of thinking about the whole experience as a counselor in community mental health. It sounds like you'll have some really valuable things to share about that past experience as well.

Participant: Mmm hmm (affirmative).

Interviewer: Yeah. I can imagine you do. Sort of to shift gears here at the beginning for just a moment, researchers have found that experience level along with sometimes the setting that we work in as counselors can impact what's called professional quality of life. I had you take the professional quality of life scale as part of that survey. I wanted to give you the opportunity, if you could, just to talk a little bit about what your experience taking that measurement was like for you, and did it bring up any thoughts or feelings about that?

Participant: It did. It made me realize that I genuinely do like my work.

Interviewer: Good!

Participant: Sometimes I get tired, and sometimes I get a little burnt out and frustrated with it, but overall it made me realize that I really do like what I'm doing.

Interviewer: OK, good. I noticed your scores, your compassion satisfaction was very high. That's definitely a positive. Your secondary traumatic stress and your burnout scores were relatively low. Do you think that there would

have been any difference if you had taken this before, when you were in your other role?

Participant: Yes.

Interviewer: Yes?

Participant: I probably would have- my burnout level probably would have been a little higher. A lot higher, yeah.

Interviewer: A little higher for the burnout, OK. Yeah. Anything else that it brought up for you about working in community mental health?

Participant: Let me think ... No. I don't think so.

Interviewer: No? OK. It sounds like it was a good experience to take that measurement, and it helped you to recognize that you enjoy what you do.

Participant: Yes, definitely.

Interviewer: Good. Well, tell me a little bit about why you chose to work in community mental health. We have lots of options as counselors, and community mental health is just one of those things.

Participant: Right. I started out finishing up my grad program, and I did not want to work in community mental health. I heard horror stories. I did not think I could work with children. I did not want to go into anyone's home. I was praying and crossing my fingers for more private practice, group practice, office setting work. My internship, I did at the counseling center at my university. So ultimately, I wanted that type of setting. But, as an entry level counselor, those types of settings aren't readily available. So I had to go start my work in the field.

When I left my previous mental health setting- in home setting, I still did not want to go back in the home, because it was not the best experience. But then when I started working for this current agency, it became a better experience, because I could become more of an independent counselor and do things the way I saw fit to do them, and create a very healthy environment for myself and the client. I started out not wanting to be in community mental health at all, but as time has progressed, I have learned to love it because I see the need in the community, and I see that we can really do valuable work when they go in the home. I know that that work would not be done if that type of client had to come to us.

Interviewer: OK. So starting out, this was not something you wanted.

Participant: No.

Interviewer: You had heard horror stories, and it didn't seem like the best fit to go into people's homes. And then as you have had the experience, it sounds like you have enjoyed the flexibility of it, and being able to be the counselor, and the type of counselor that you want to be, and to work with the clients in the way that you feel most appropriate.

Participant: Right.

Interviewer: OK, so it's become something that you enjoy. What types of things did you hear about community mental health way back that said, no, I don't want to do that?

Participant: Well, I heard you have a heavy, heavy course load. Or caseload, rather. I heard of issues of fights in the home while the counselor was present. I heard of the clients trying to manipulate the counselor to buy them things and take them places. I heard that bugs, bedbugs and things are in the homes and, you know, it's not a pleasant working environment.

Interviewer: Yeah, and would you say you've had any experiences with those kinds of things since being in the home?

Participant: Mmm hmm (affirmative).

Interviewer: Yes?

Participant: I have.

Interviewer: Sometimes it's safety issues, sometimes it's cleanliness issues?

Participant: It is. Because when you go in the home, you kind of want to just be as natural as possible, as natural as the client is in their home, and you don't want to seem like, you know ... put off by their home environment because we want to build an empathic rapport, like, hey, whatever you have here is fine. Even though in your mind you're like, this is not fine!

Interviewer: Right. Yes, I can relate to that experience, for sure. Yeah. So those were the kinds of things that you had heard about, and you didn't really think that it was a good fit for you. You've adapted, apparently, over the years, though that.

Participant: Yeah. I was terrified of working with children. Most of the clients that receive Medicaid is a child. Children, adolescent population. I was not sure of how I could reach a child through therapeutic means. With our program, we weren't trained with play therapy. We were trained ... We did a couple courses with adolescent psych, but nothing like engaging with a child. I didn't have, for a practicum or internship, experience working with children. So I was really afraid of that at first, and my first case load was all children. But you learn. You learn as you go along.

Interviewer: You didn't feel prepared for working with children, specifically, but you sort of gained those skills over the course of this experience.

Participant: Right, right.

Interviewer: OK. Wow. Well, thinking about, you know ... You work specifically with Medicaid. Was that also the previous experience, too? Primarily Medicaid?

Participant: Yes.

Interviewer: OK. One of the things we know about community mental health organizations is that, often there are additional responsibilities that don't necessarily equal client care, or direct client care. So things like documentation, maybe compliance issues, organizational things that need to be done and have to be taken care of that sometimes take us away, or are just simply different from client care.

Participant: Right.

Interviewer: I wondered if you could tell me a little bit about your experiences with some of those additional responsibilities, besides the direct counseling aspect of things.

Participant: The paperwork has been a headache. It has. I enjoy doing the assessments. I procrastinate terribly with writing it up, because it does take time, and it's not a direct contact hour, so it's time spent away from making money, but it's time spent learning and really thinking about the client and where they are. So it's valuable, but it's just not making you any money at that moment.

We've had a lot of new paperwork here at this current agency this year that we didn't have to do last year, and things were being updated every few months, it seemed like, at one point. I'm not sure why. I'm not sure if that came from alliance or the powers that be or whomever, but we had a lot of extra paperwork that needed to be done. For each client- we had a packet, like really thick, like this thick- for each client that needed to be done. I know that it's necessary, but it does take time away from the counseling.

Interviewer: Sure. So you enjoy the actual process of doing the assessment. I know Medicaid assessments are very specific requirements, and even the case notes and things like that are very specific, Medicaid based requirement. But it's the paperwork piece of it that is hard. You mentioned a couple times, when you're doing that paperwork part, you're not making money. Tell me about that. Does that mean that you are contract?

Participant: Yes. Yes, I'm contract.

Interviewer: OK, so when you are not directly with a client, you're not earning money because those documentation pieces are not reimbursable.

Participant: Right.

Interviewer: Especially in the outpatient setting.

Participant: Right.

Interviewer: Tell me about that, though. Tell me a little bit about, maybe, the struggle- or if there is a struggle- the idea that you're contract, not making money. We all need money. We have to have it. How does that affect your ability to work with clients sometimes?

Participant: I mean, it's a tug of war. It's a push and pull. I know those moments where we had paperwork and we had to get it in that week, if I had an overload of paperwork, I could not see all of my clients because there just was not enough hours in a day. So if I'm spending time for the business doing paperwork, but I'm not making money at that point in time, it's frustrating if I have to swap one for the other.

Luckily that doesn't happen often. It happens maybe once a year, if I get overloaded and have to finish up all my paperwork at one time. So that is a push and a pull. I do know of other clients that work for larger agencies who get paid a different rate, you know, for non direct hours and things like that. You know, that's nice, but I do enjoy the flexibility of the type of

agency that I work for. Because I am contract, I have that greater sense of independence, so I guess I have to lose out on some other things.

Interviewer: OK. So it's kind of been worth it for you for that independence.

Participant: Yeah, it has.

Interviewer: But it can be frustrating.

Participant: Yeah, it can.

Interviewer: OK. Anything else that you would maybe talk about impacting your ability to work directly with clients as a counselor, related to maybe those additional responsibilities?

Participant: No. I don't think so. I've really found that the parents don't mind ... Sometimes the parents don't like filling out all the paperwork, but they don't mind working with me to do it. At first I thought, oh, gosh, the parents aren't going to like- some of my parents don't like to fill out paperwork at all. So they're not going to be on board when I say, oh, I can't see your child this week, but we have to do paperwork. Most of them have really been understanding of it.

Interviewer: Oh, that's good.

Participant: Yeah.

Interviewer: So you were a little worried at first thinking they wouldn't be on board, and it's been surprising.

Participant: Mmm hmm (affirmative).

Interviewer: OK, great. Tell me a little bit more, then, about the types of clients that you work with. You mentioned children and adolescents, primarily, but maybe tell me a little bit more about that. Some of the issues that tend to be trending ...

Participant: OK. Right now, I see a lot of what's being diagnosed as ADHD. It's a lot of distractability, but these are also homes where there are a lot of things going on. There's not a lot of structure in some of these homes, and the kids need a place of structure and accountability and self responsibility management type of stuff. I am seeing some depression, especially in the homes where mom may be in and out, or families may have multiple folks taking care of them. Grandparents taking care of them, dad taking care of them at this point in time, mom taking care of them at that point of time. A lot of sibling rivalry in some of the blended families. Some anxiety. Some anxiety with some of the younger clients that I'm coming into contact with. I'm not sure- that's a fairly new trend. Fairly new. I haven't seen that previously, but I've started getting a couple clients with seemingly early perfectionistic tendencies, but over the course of time it's been mainly ADHD and depressive symptoms.

Interviewer: I'm kind of looking back over ... I don't see that you checked much trauma. It looks like you checked some sexual assault issues, ADD/ADHD, for sure. Some PTSD- no. NO real PTSD, so anxiety, grief, loss, things like that. One of the things you checked is housing and homelessness.

Participant: Mmm hmm (affirmative).

Interviewer: Tell me a little bit more about that.

Participant: A couple of my clients have been homeless. Not living on the street, homeless displaced, living with other family members. 2 families that I'm thinking of, in particular, during the course that I've been seeing them, they've lived, OK, let's say ... 3. 3 families? 4. OK. 4 families. It keeps going up. Several, apparently, as I think about it, of the families have had to live in a shelter, have had to live in a hotel, have had to live with extended family. So it would be mom and kids or kids go to live with the grandparents for a certain period of time, kids go to live with dad for a certain period of time. It's a lot of displacement. They're never out on the street. There's always a safe place for them, but it's not their home.

Interviewer: Can you talk a little bit about how some of those issues impact the way that you work with your clients? You're doing outpatient therapy, and you're doing more of an individual focus. You don't have that team around you. Talk a little bit about that. How do you work with those people?

Participant: A lot of the onus ... I think, maybe I choose for it to, but it falls on me. Because if a child ... if I start working with a child in a certain area in Raleigh, and then they move across town in Raleigh, and then they move to one city, then they move to another local city, I move with them. I know that the kids need consistency. That's one of the main things that I try to help them with, a sense of consistency and order. Sometimes knowing that I will come every Thursday, no matter where I am, creates that consistency for them, so I have had to change my own schedule and be flexible so that I can accommodate and stick with the client and the family for the duration of time that I need to, even if they do move 20 minutes away.

Interviewer: So it impacts you very much on a location basis. Where you are doing your therapy. How about- when you're dealing with an issue such as housing or homelessness- how does that impact your ability to work in the session with that client? Or do you see it impacting your ability to work with the client?

Participant: With the clients ... most of the kids, they're resilient. They're very resilient. Oh my gosh, they're so resilient. I think as long as they feel safe, you know, it comes out, you know, in some of their anger management issues, and it comes out in various ways. But it doesn't really impact it. We kind of let it roll, as it sees fit, and not make a whole big deal out of it. I know with some of the kids, they get embarrassed when they have to move around, or they get embarrassed when they get kicked out. I want them to have a safe space to express that, but I don't want to bring it up as, I see it as a hindrance to our relationship, you know?

Interviewer: OK, good. Yeah, I like that. Kids are definitely resilient, for sure. They're amazing. Not really switching gears completely, but thinking about all those difficult issues that clients face and how you make adjustments as a counselor to deal with those, thinking about how those might impact you,

as a person. So, personally and professionally, maybe, too. How do you see that impacting you?

Participant: It has. It's made me a lot more patient. I've grown in my flexibility. I've grown to be less rigid with my structure and my own time. I've really learned a lot about this type of business and accepting it as something that I am doing right now, because it really does become all about the client and what's best for the client. My business is making sure that I'm doing what's best for the client to make sure that they feel safe and supported. Of course, it takes me out of my way and ... I think I've learned from it. I used to be a lot more frustrated with it, and a lot more ... I guess, angry with the system. But as I learned that these patterns are just always going to keep happening. I can't do anything to change, unfortunately, some of the things that go on in these houses. I can support it, at best, and influence it, at best. I think it's made me a lot more patient and flexible and ... yeah, patient and flexible with this thing.

Interviewer: OK, patient and flexible. You've had to adjust the way that you see things.

Participant: Yeah, definitely.

Interviewer: You mentioned, angry with the system. Can you expand on that? What did that mean for you?

Participant: Yeah. For me to be angry with the system would be the way that outpatient in home therapy works. I've always had a choice, you know? I could say, this isn't for me, I don't want to do this anymore. I'm going to go look for another job. Or I could say, no, I don't want to move with the client, I want to see other clients in this vicinity. Or I could say, you know what? I like my caseload, I like my clients, I'm willing to kind of be flexible with it. So to be angry with the system would be upset at the way things are going, knowing that I can't change it, but stay upset with it.

Interviewer: Sometimes that system is ... it definitely isn't very flexible. It changes a lot, but you don't really have control over what it happening within the system. So you're kind of saying, you have the choice to either be angry with the system and stay angry and let that impact you, or to be flexible and adjust.

Participant: Right.

Interviewer: OK, yeah. That makes a lot of sense, for sure.

Participant: Being angry doesn't really get you anywhere. It doesn't, you know ... You lose a client, you're not going to gain a client, necessarily. You might be afraid of what's going to happen to your client if they have to go to another counselor. I don't want to disrupt the client's life anymore than it already is disrupted.

Interviewer: Trying to be that consistency for them, it seems very important to you.

Participant: Mmm hmm (affirmative).

Interviewer: Good. OK. Well, kind of thinking about that, how would you say that you deal with stress of the job? Thinking about self care. What does that look like for you?

Participant: Well, I do take breaks. I take a lot of breaks every day. In addition to working in counseling, I work in ministry. I guess both of those are caring professions, so to speak. During the day, I will take my hour or two to myself, and try to eat regularly. I don't exercise, but I do try to drink plenty of water and stay hydrated, and do little things to take care of me. I do try to have my spiritual time and things like that that are just personal, for me to do, so I feel like I'm getting the strength and help that I need.

Interviewer: So not only physical things, like eating and drinking water, taking care of yourself that way, but you look to a spiritual source for strength as well, and that makes a big difference for you.

Participant: Mmm hmm (affirmative). It does.

Interviewer: All right, good. All right. Now shifting gears a little bit, one more time here. Thinking about all the work that you do and have done in your experience with community mental health, what would you say has prepared you for that type of work?

Participant: That's a good question. What has prepared me for the work in community mental health? I think I've always been a compassionate person. I've always been the helper in whatever situation that I've been in. I've always been the listening ear. When I made the decision to go into mental health, to be a counselor specifically over other types of mental health positions, it's because we advocate for a listening ear. We don't advocate to necessarily change a person or get into their mind and see what's wrong with them, but we offer them support and a place to express themselves, however that may be. I've always wanted to be that person, and now I have the opportunity to do it professionally. I think I've been preparing for it probably most of my life. It's a part of me. It's a part of what I do naturally, and now I have the skills to do it professionally.

Interviewer: Recognizing in yourself whatever- maybe we would call it personality, maybe personality traits, for lack of a better term. Compassionate, enjoying, allowing people to just express themselves and listening. When you started to look for career paths, counseling seemed to fit for you in that it- you know ... yeah, counseling is a very strength based field. We don't look for the pathology, necessarily, we look for supports and expression. It seemed to fit for you. You feel like you've just sort of always been preparing for this type of work and the formal education gave you the skill set to do it.

Participant: Right. Exactly.

Interviewer: What a great thought, that your whole life you've been preparing for this type of work. I think I can relate to that a little bit, too. All right. OK. So one last shift in gears, here. I want to talk a little bit about supervision. We tend to believe that counselor development is facilitated most often by supervision. It's also a requirement for licensure, so whether you like it or not, there you go. Can you describe a little bit about your supervision experiences?

Participant: I've had the same supervisor, since I started working as an LPCA. She's been consistently there for me. I see her ... When I first started, I started with once every ... twice a month. And now it's gone to 3 times a month. I really enjoy supervision. We talk about the cases, we talk about my personal growth and development in the field. She's very, very helpful for everything that I need.

I wanted, when I first started, to get supervision at the agency, because I knew that would be a cheaper option, I had heard. But it was not available at my first agency. There were some weird things going on there, because at one time, we had to get supervision at the agency, but it was from a social worker. So that didn't count. That was like agency supervision, but it didn't count toward my general supervision hours, because she wasn't contracted through the board to supervise me. That kind of created a ... I'm not sure if I'd say imbalance. It was something. I was getting supervision hours from 2 different places, but only able to count one.

Interviewer: It sounds like you had to pay for the one that counted.

Participant: Right. I did. So I didn't have to pay for the one that didn't count, but I do have to pay for the one that did count.

Interviewer: You had hoped originally to get supervision from within the agency, simply because of cost, and when that didn't work, you looked for someone who was qualified by the board.

Participant: Right.

Interviewer: Were they ... that agency, were they willing to reimburse you for supervision costs?

Participant: Mmm hmm (negative).

Interviewer: No. OK. Currently, are you getting any kind of reimbursement for your supervision costs?

Participant: No.

Interviewer: No. OK. You've had a couple of different experiences, then, with supervision. You've had the consistent clinical supervisor, which sounds like she's been really great. You've really enjoyed working with her. And then you've had the experience where you had the in agency social worker who was supervising you. Can you talk about any advantages or disadvantages that you experienced with that, besides the fact that the social worker didn't count toward your licensure hours. I'm just wondering if there's anything about the dynamic of being in the agency versus having a supervision outside the agency, things along that line.

Participant: I felt like it was helpful at times, but unnecessary at other times. Again, that was another thing that I had to do that wasn't cost efficient for me. I would have to go to the agency to get supervision for an hour, which was free through the agency and discussed those cases. But, it was gas. It was time away from billable hours, especially when I already had a supervisor that I was paying for, and that counted.

Interviewer: OK. But they required it? The agency required that you got supervision?

Participant: Mmm hmm (affirmative). And we also had ... in addition to the supervision with the L ... the social worker, LCSW, we had supervision with the psychiatrist, also. All of us would meet- all the LPCAs would meet with the psychiatrist regularly, once a month, I think, to discuss our cases. It was good. I learned a lot. I did learn a lot. But kind of I would have to adjust my schedule. Sometimes it would run over. I had a lot of other things going on at the time. It wasn't ... the best thing for me, so to speak, at that time.

Interviewer: It sounds like that type of setup where you had a lot of supervision from different places and people, the inconvenience factor sometimes made it difficult.

Participant: Mmm hmm (affirmative).

Interviewer: But you said you learned a lot, so it sounds like it probably gave you some different perspectives on client care, but it certainly didn't make it easy.

Participant: Right.

Interviewer: What kind of positive and negative things about supervision would you share? What are some good things, what are some maybe other struggles that you have with supervision?

Participant: With supervision, I feel like I have someone to check things out with. You know, when we're appearing for people emotionally, I know I always feel like I'm doing something wrong. I never want to say something or interpret something the wrong way that would leave a person in a more fragile state than they were when they sought out my help. It's kind of like a person to check in with like, did I say this right? Listen to this tape. Did this come out right? Could I have said something differently or recovery-framed in another way, and then what's the next step do I take now, because I don't know where this client is going from here. Of your experiences, where could I go with this. I think it's very helpful from that standpoint.

One thing that I have had conflict with as I'm going to finish my licensure as an LPCA soon, within the next few months, is the conflict with the finishing. I should be done supervision hours by February, but I'm going to have to wait until, I think, May or June for the board to finish with all of my stuff, so then I'll have to keep having supervision for 2 or 3 months, I think, until they get all my stuff and approve it. Maybe more than that. I'll keep getting supervision even though it'll kind of be unnecessary by that point, but I've got to keep getting it.

Interviewer: It sounds like that creates a financial burden, and also kind of a time burden, as well.

Participant: Yeah.

Interviewer: That's been a pretty big theme, along with hearing from folks. It sounds like agencies are more and more going to this contract model, and with that, not providing or reimbursing for supervision. Whereas, I think maybe in the past, one of the positive things people would look for in community

mental health was, OK, this is a way for me to pay my dues, learn a lot of skills, and get free supervision.

Participant: I wish.

Interviewer: Yeah, it sounds like it's kind of trending in the other direction. I think that's really interesting for me to hear. Yeah. OK. Participant, what else kind of comes to mind? Anything else about your experiences with community mental health as sort of a newer, or entry level professional?

Participant: No, I mean ... I like it. One thing that it can be kind of taxing is the driving, the drive time. I do live in one city, and most of my clients are in another city. I spend 30-40 minutes each way, and then from house to house to house, which, again, does take away from billable hours. But it does give me a chance to think about what I'm going into and what techniques can be used, and things like that. I think early on, that did create some stress on my body, getting used to being in the car so much. I think I've gotten used to it, but I can tell that over time I'm going to want to do less of that for my personal health, and for my car. I've put like ... I think I've put like 30,000 miles on my car in one year.

Interviewer: So you're using your personal car, you have to use your finances. Do you get any kind of reimbursement or mileage through the agency, or do you have to submit that to your-

Participant: I submit it on my taxes.

Interviewer: Taxes. Oh, OK. Which, I guess you get it on the other side, but you have to foot the bill upfront.

Participant: I do.

Interviewer: OK. That's a tough situation, I think, to be in for maybe a lot of newer counselors, coming right out of school, and student loans coming due, and all kinds of fun things. Then you're limited with that restricted license what you can do and how much you can make, anyway.

Participant: Right.

Interviewer: OK. Yeah, so some really good information. Thank you so much for doing this. Any- I want to give you just one more chance- anything else that you would say?

Participant: No. No, I like the work that I do. I think I ... Since working in this type of environment, other jobs have come up for me, more stable- I've been offered a job again at the counseling center a few times, and I chose not to take it, because I actually prefer the work that I'm doing in the community and I didn't think that I would. Even with everything that I throw out of the not so goods, something keeps pulling me to stay in this type of work, because I feel like it's valuable.

Interviewer: That job satisfaction, or I guess I should say compassion satisfaction, seems to override some of the other negative factors for you.

Participant: It does.

Interviewer: That's really great. Participant, we are done with the interview portion. I really appreciate your help with this.